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ABSTRACT

This book provides a collection of current and historical data on some of the most pressing health challenges facing women, their families, and their communities. It is intended to be a concise reference for policymakers and program managers at the federal, state, and local levels. The book brings together the latest available data from various agencies within the federal government. Three chapters focus on: (1) "Population Characteristics" (U.S. population, U.S. female population by race, women and education, women in health professions schools, women in the labor force, women and federal programs, participation, and women and poverty); (2) "Health Status" (health behaviors, health indicators, maternal health, and special populations); and (3) "Health Services Utilization" (usual source of care, health insurance, Medicare and Medicaid, preventive care, Title X family planning services, Title V abstinence education, programs, HIV testing, medication use, dental care, hospitalizations, mental health care utilization, home health and hospice care, and health care expenditures). (SM)

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Women's Health USA 2003

U.S. Department of Health and Human Services

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Women's Health USA 2003

U.S. Department of Health and Human Services

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PREFACE AND READER'S GUIDE

"Healthy Women Build Healthy Communities" is the principle that guides the work of the Health Resources and Services Administration (HRSA) to improve women's health. As an agency in the United States Department of Health and Human Services, HRSA is charged with assuring access to quality health care through a network of community-based health centers, maternal and child health programs, and State, Territorial, and community HIV/AIDS programs. In addition, HRSA's mission includes supporting individuals pursuing health careers in medicine, nursing, and many other health disciplines. HRSA fulfills these responsibilities by collecting and analyzing timely and topical information that identifies health priorities and trends that can be addressed through program interventions and capacity building.

HRSA's Maternal and Child Health Bureau (MCHB) and the Office of Women's Health are pleased to present *Women's Health USA 2003*, the second edition of the *Women's Health USA* data book. To reflect the ever changing, increasingly diverse population and its characteristics, *Women's Health USA 2003* will selectively include emerging issues and trends in women's health. Data and information on incarcerated women, immigrant women, breastfeeding, medication use, bleeding disorders, and HRSA programs and populations are a few of the new topics included in this edition. Where possible, every effort has been made to highlight racial and ethnic disparities as well as sex disparities.

The data book was developed by HRSA to provide readers with an easy-to-use collection of current and historical data on some of the most pressing health challenges facing women, their families, and their communities. *Women's Health USA 2003* is intended to be a concise reference for policymakers and program managers at the Federal, State, and local levels to identify and clarify issues affecting the health of women.

Women's Health USA 2003 is modeled after another data book produced by HRSA, *Child Health USA*. Now in its thirteenth edition, *Child Health USA* has become a useful tool for family advocates, policy makers, and organizations to track key indicators of child and adolescent health. The books address common themes, including population characteristics, health status, and health services utilization. Together, the two publications should be considered companion documents.

In these pages, readers will find a profile of women's health from a variety of data sources. The data book brings together the latest available information from various agencies within the Federal Government including the U.S. Departments of Health and Human Services, Agriculture, Commerce, and Justice. Non-Federal data sources were used when no Federal source was available. Every attempt has been made to use data collected in the past five years.

It is important to note that the incidence and mortality data included is generally not age-adjusted to the 2000 population standard of the United States. This affects the comparability of data from year to year, and the interpretation of differences across various groups, especially those of different races/ethnicities. Without age adjustment, it is difficult to know how much of the difference in morbidity and mortality rates can be attributed to different age distributions. Also, presentation of racial and ethnic data may appear different on some pages as a result of the design and limitations of the original data source.

Women's Health USA 2003 is available online on the HRSA Office of Women's Health website at www.hrsa.gov/womenshealth. In the effort to produce a timely document, some of the topics covered in *Women's Health USA 2002* were not included in this year's edition because new data were not available. For coverage of these issues, please refer to *Women's Health USA 2002*, also available online.

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INTRODUCTION

Women comprise more than half of the U.S. population. In 2001, the U.S. population reached 277 million, with females representing 51 percent of the total population. The U.S. female population is increasingly racially and ethnically diverse and women continue to comprise a larger proportion of our nation's elderly population.

Over the past three decades, the number of college degrees awarded to women has increased from 518,000 in 1969-1970 to 1.3 million in 1999-2000. In 1999-2000 women were awarded a greater proportion of the associate, bachelor's and master's degrees than men. In addition, women make up an increasing percentage of enrollees in schools of medicine, dentistry, pharmacy, and public health.

The number of U.S. females 16 years and older in the labor force has grown to over 62 million. Women represent the majority of employees in the sales and office occupations (63.7 percent) and service sector (56.7 percent). However, disparities continue to exist in incomes between men and women, with women earning 76 cents for every dollar earned by men.

Poverty continues to disproportionately affect women in the U.S. In 2001, 12.8 million women and 8.4 million men aged 18 and older were living with incomes below the Federal poverty level. Among selected household types, female-headed households had the highest rates of poverty, followed by females living alone, 26.4 and 19.2 percent respectively. The Supplemental Food Program for Women, Infants, and Children (WIC), and the Federal Food Stamp programs are nutrition programs that assist needy families and individuals with purchasing nutritious foods. In 2001, 70.3 percent of all adult Food Stamp program participants were females while the number of adult women participating in WIC reached nearly 1.9 million in 2000.

The Federal- and State-funded Temporary Assistance to Needy Families (TANF) program provides cash assistance and work opportunities to needy families. In 2000, adult TANF recipients numbered 1.6 million, of whom 1.4 million were women (90 percent). Ninety-three percent of adult TANF recipients were heads of households and two-thirds were of a minority racial or ethnic group.

People with health insurance are more likely to have a regular source of medical care and to use preventive care, while people without health insurance are more likely to have unmet medical needs. In 2001, non-Hispanic White females were the most likely to be covered by private insurance (77.9 percent) as compared to other racial and ethnic groups and the least likely to be uninsured (9.3 percent). Hispanic women were most likely to have no usual source of care (20.8 percent).

Immigrants, especially non-citizens, face special challenges in accessing health care services, including language and cultural barriers. In 2001, women who were non-citizens were more likely than naturalized citizens and U.S.-born women to lack a usual source of health care (18.9 percent of non-citizens as compared to 11.2 and 9.4 percent of naturalized and U.S.-born citizens, respectively). Also, non-citizen women reported having gone longer than citizens without seeing a health care provider.

Although the rate of incarceration for women is much lower than it is for men, from 1990 to 2000, the total number of women in Federal and State prisons and local jails nearly doubled from 83,253 to 165,649. Approximately 58.8 percent of women in State and Federal custody have minor children.

The Health Resources and Services Administration (HRSA) serves all women, including uninsured and underserved women; rural, migrant, and immigrant women; homeless women; women living with HIV/AIDS; and pregnant women. In 2002, 59.3 percent of the clients served by HRSA-supported health centers were women. The majority (84.8 per-

cent) of women 18 years and older served at these health centers were up-to-date for Pap smears, and those 50 and older had high rates for mammography and clinical breast exams. Rates for community health center clients were higher than national averages for both Pap smears and mammography.

Women are more likely than men to seek preventive care. In 2000, females made 488 million office visits and males made 335 million. Of these visits, females made a greater proportion for preventive/non-illness care (21.2 percent) than men (14.7 percent), although the inclusion of pregnancy-related examinations in the non-illness category could account for some of the observed difference. Dental care is an important component of preventive services. In 2001, the majority (66.7 percent) of women reported having visited a dentist in the last year while 12.0 percent reported they had not visited a dentist in over 5 years. Immunizations are also an important component of preventive care. Among women aged 65 and older, non-Hispanic White women obtained the highest rates of annual influenza (flu) vaccination and lifetime pneumococcal vaccination in 2001.

Healthy behaviors, like regular physical activity and healthy nutritional choices, are critical to a long and healthy life. Unfortunately, women are less likely to engage in light or moderate leisure time physical activity than men. They are also less likely to consume recommended servings of fruits and vegetables. However, vitamin-mineral supplement use is common, with nearly 57 percent of U.S. women taking at least one vitamin-mineral supplement in the year 2000.

Maintaining the health of women during and after pregnancy is integral to life-long health. Over 3.9 million women gave birth in 2001; however almost 42,000 of these women delivered without benefit of prenatal care. The growing proportion of births to women 35 years or older and excessive weight gains in pregnancy prompt concerns about chronic conditions and subsequent obesity. Breastfeeding, with its numerous benefits for women and their infants, has increased to the highest recorded rates both while in the hospital and at six months postpartum.

Mental health is a critical component of a person's overall health. More women than men report serious mental illness across all age groups. Higher suicide death rates are reported for both non-Hispanic White and Asian/Pacific Islander women than other racial and ethnic groups (4.7 and 4.6 per 100,000 females respectively). Despite these needs, in 2001, 5.7 million women reported an unmet need for mental health treatment or counseling. Nonetheless, the estimated number of women receiving mental health treatment or counseling increased in 2001 to 14.4 million from 13.2 million in 2000.

Substance abuse is also an important health concern among women with 27.3 percent of women aged 18-25 and 20.5 percent of females aged 12-17 having used some type of illicit drug in 2001. Marijuana/hashish was reported as the leading illicit drug used by women of all ages.

Some health conditions are more prevalent among women than men, including arthritis, lupus, and bleeding disorders. Arthritis is the leading cause of disability for women, while lupus is the most commonly diagnosed autoimmune disease and von Willebrand Disease is the most common bleeding disorder in women. Women are also disproportionately affected by such conditions as diabetes and asthma. The prevalence of diabetes mellitus increases with age and is higher among people who are overweight or obese. Racial and ethnic disparities also exist with the rate for non-Hispanic Black women nearly twice the rate for non-Hispanic White women and 1.5 times the rate for Hispanic women in 2001. Women with diabetes mellitus face special concerns, including an increased risk of heart disease, blindness

and complications during pregnancy. In 2000, diabetes mellitus was the fifth ranked cause of death for U.S. females, accounting for 37,699 deaths. Women are also more likely to suffer from asthma, with women aged 64 and younger experiencing asthma at nearly two times the rate of men.

Heart disease is the leading cause of death for women in the U.S. with 365,953 women dying in 2000. For other major causes of death including cancer and stroke, women die at lower rates than men.

The second leading cause of death for women is cancer, accounting for 267,009 deaths in 2000. Representing a quarter of all female cancer deaths, lung/bronchus cancer was the leading cause of cancer mortality, followed by breast cancer and cancer of the colon and rectum. Although lung cancer kills more women, more women are diagnosed each year with breast cancer than any other type of cancer. From 1992 to 1999, the incidence rate of breast cancer among U.S. women increased nearly 5 percent, from 129.8 per 100,000 women in 1992 to 135.9 in 1999. In 1999, White women had the highest incidence rates of breast cancer (140.8), followed by Black women (120.9). Although White women have a higher incidence of breast cancer, Black women have higher death rates from breast cancer. Between 1995-2000, the percentage of women who smoked remained steady at slightly more than 20 percent of women aged 18 and older. Of particular concern is that adolescent girls report smoking cigarettes at slightly higher rates than boys (13.6 percent compared with 12.4 percent). In 2001, 23.0 percent of females aged 12 and older reported smoking cigarettes within the past month.

Two other health concerns on the forefront of the women's health agenda are HIV/AIDS and violence against women. In 2001, there were 11,082 AIDS cases among U.S. females aged 13 years and older attributed to three major exposure categories: heterosexual contact, injecting drug use, and undetermined modes of transmission. Of cases in females with known transmission sources, 37.4 percent were exposed through heterosexual contact. In 2001, females accounted for 25.8 percent of all diagnosed AIDS cases.

Women are more likely to experience a violent crime perpetrated by a friend or acquaintance while men are more likely to be victimized by a stranger. While the overall prevalence of violence against women in 1999 was 5.8 per 1,000, among women aged 16-24 years it was 15.6 per 1,000. For all racial and ethnic groups, intimate partner violence experienced by women peaks between the ages of 20-24 years. Black women within this age cohort experienced victimizations at a rate of nearly one and a half times that of White women. Additionally, women are more likely to be victims of homicide by intimate partners and report the majority of sexual assaults and rapes.

As the number of older Americans grows, attention is also focused on the care of seniors. In 2000, 64.8 percent of home health care service recipients were women. Increasing numbers of women and men are also using hospice care to meet their end-of-life needs. Between 1992 and 2000, the number of hospice care patients doubled. In 2000, women outnumbered men among hospice care patients with 60,600 females compared to 44,900 males.

Women's Health USA 2003 provides the information for tracking our efforts to help shape a healthy future for all Americans. These statistics show significant advances in women's health, yet challenges remain. Advances in medical research and treatment promise solutions to some of our most pressing conditions, such as heart disease, diabetes, cancer, and HIV/AIDS, while behavior change and personal responsibility provide opportunities to further improve our health and quality of life. Healthy women build healthy communities.

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POPULATION CHARACTERISTICS

Population characteristics describe the diverse social, demographic, and economic features of women in the United States (U.S.). Representing slightly more than half of the Nation's population, women and girls number approximately 142 million.

Analysis and comparison of data across gender, age, and race and ethnicity can be used to tailor the development and evaluation of programs and policies serving women's health.

The following section presents data on popu'ation characteristics that affect women's health. These indicators include age, race, education, income, occupations, and participation in Federal programs.

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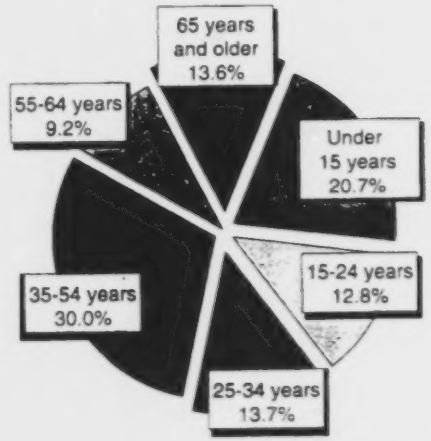
U.S. POPULATION

In 2001, the U.S. population reached 277 million, with females representing 51.2 percent of the total population. Females under age 34 accounted for 47.3 percent of the female population, those aged 35-64 represented 39.2 percent, and females aged 65 and older accounted for 13.6 percent.

The population of women and men was very similar for all age groups, with the exception of a significantly larger number of women in the older age group. Of people aged 65 and older, 58.0 percent were women.

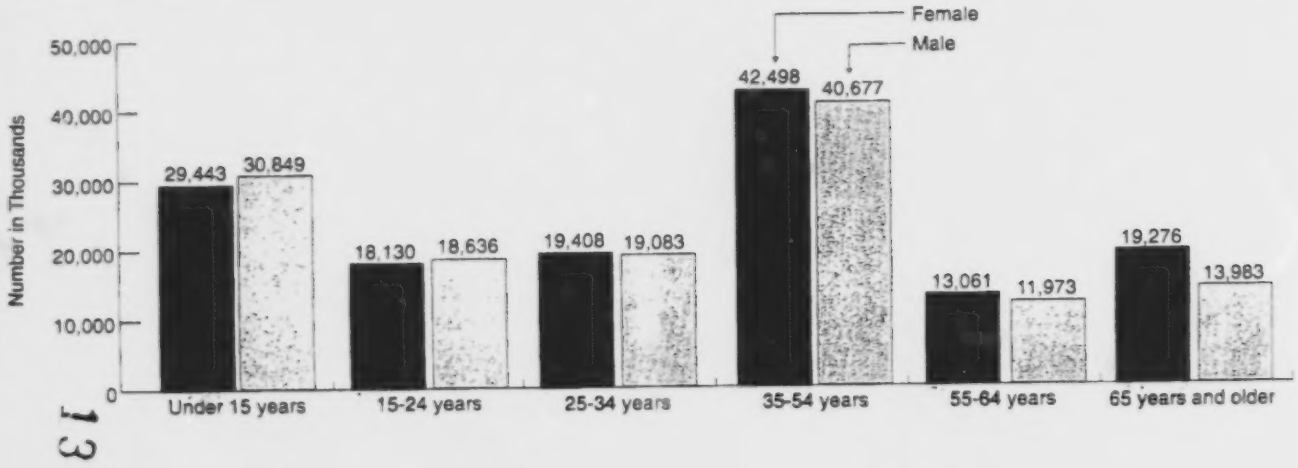
U.S. Female Population, by Age, 2001

Source (T.1): U.S. Census Bureau



U.S. Population, by Age and Sex, 2001

Source (T.1): U.S. Census Bureau



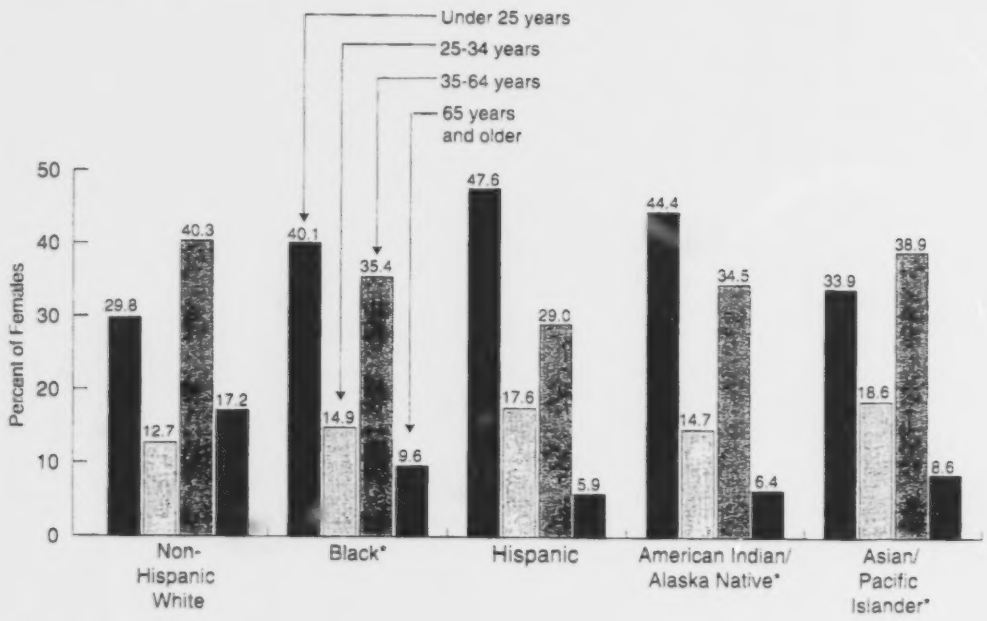
U.S. FEMALE POPULATION BY RACE

The female population in the U.S. is growing increasingly diverse. This diversity is reflected in the racial and ethnic distribution of women by age group.

In 2000, a larger portion of the non-Hispanic White women were aged 65 or older (17.2 percent) as compared to other racial and ethnic groups (9.6 percent of Black women, 5.9 percent of Hispanic, 6.4 percent of American Indian/Alaska Native, and 8.6 percent of Asian/Pacific Islander females). The proportion of females aged 25 years and younger is much higher in non-White racial and ethnic groups, with 47.6 percent of the female Hispanic population, 44.4 percent of the female American Indian/Alaska Native population, and 40.1 percent of the Black female population within this age cohort.

U.S. Female Population, by Age and Race/Ethnicity, 2000

Source (1.2): U.S. Census Bureau



*Does not exclude Hispanics

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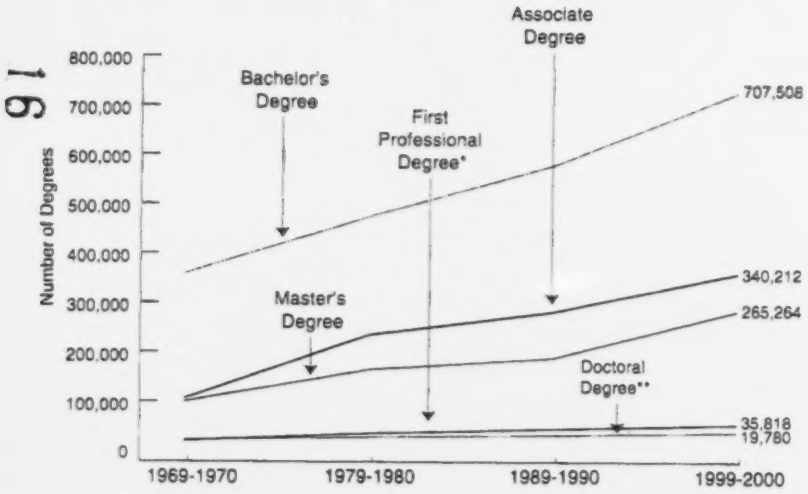
WOMEN AND EDUCATION

The number of educational degrees awarded to women has increased dramatically over the past three decades from 518,294 in 1969-1970 to over 1.3 million in 1999-2000. Although the numbers for every type of degree have increased, the largest growth has been in professional degrees, growing from 1,841 in 1969-1970 to 35,818 in 1999-2000.

In 1999-2000, females obtained a greater percent of the associate, bachelor's and master's degrees awarded. This reflects considerable gains from 1969-1970, when males were more likely than females to be awarded post-secondary degrees of all types. Although males were still more likely than females to earn professional and doctoral degrees, the proportion of professional degrees awarded to women increased from 5.3 percent in 1969-1970 to 44.7 percent in 1999-2000. While only 13.3 percent of doctoral degrees awarded in 1969-1970 went to women, this proportion more than tripled to 44.1 percent in 1999-2000.

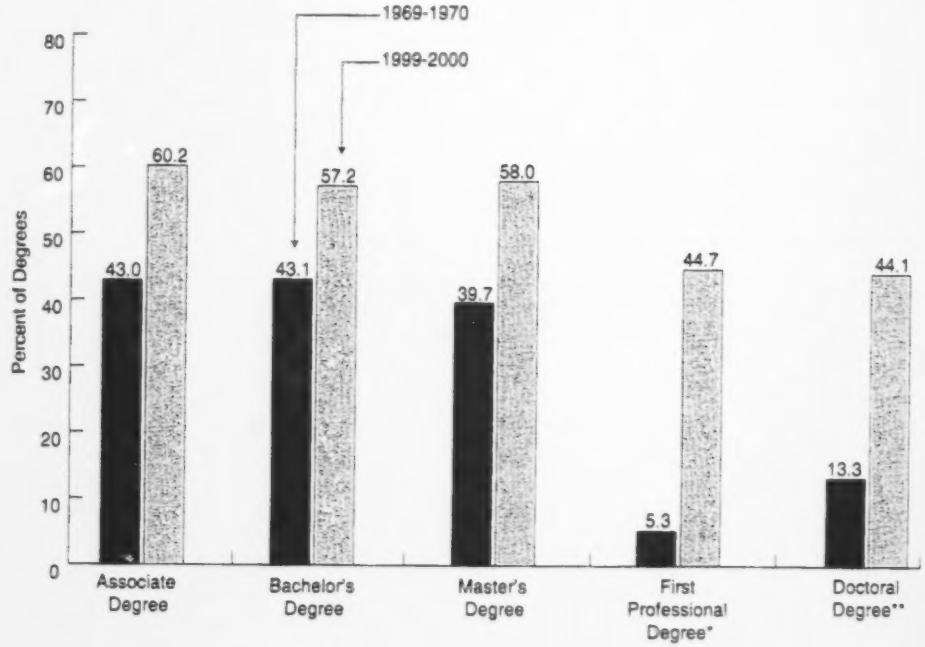
Degrees Awarded to Women, by Type, 1969-2000
Source (I.3): U.S. Department of Education



*Includes fields of dentistry (D.D.S. or D.M.D.), medicine (M.D.), optometry (O.D.), osteopathic medicine (D.O.), pharmacy (D.Phar.), podiatry (D.P.M.), veterinary medicine (D.V.M.), chiropractic (D.C. or D.C.M.), law (LL.B. or J.D.), and theological professions (M.Div. or M.H.L.).

**Includes Doctor of Philosophy degree (Ph.D.) as well as degrees awarded for fulfilling specialized requirements in professional fields such as education (Ed.D.), musical arts (D.M.A.), business administration (D.B.A.), and engineering (D.Eng. or D.E.S.). First-professional degrees, such as M.D., and D.D.S., are not included under this heading.

Degrees Awarded to Women, by Type, 1969-1970 and 1999-2000
Source (I.3): U.S. Department of Education

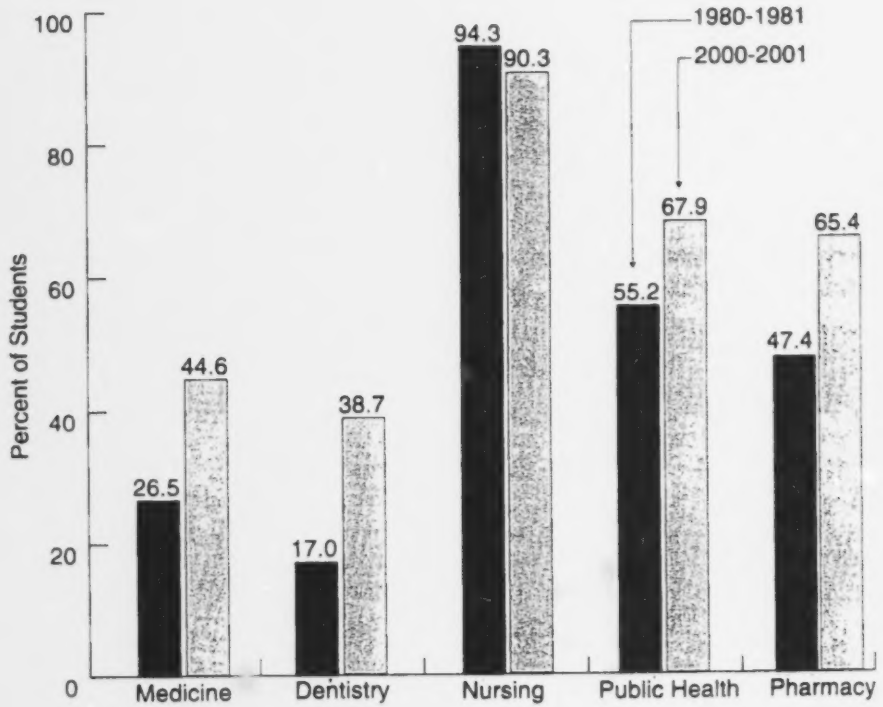


WOMEN IN HEALTH PROFESSIONS SCHOOLS

Health professions have long been characterized by sex disparities. In the past, males dominated medical, dental, and pharmaceutical schools, while women made up the majority of nursing and public health students. During the past two decades, the enrollment of women in medical, dental, pharmacy, and public health schools has increased considerably. For example, female dental students grew from 17.0 percent of total enrollment to 38.7 percent between 1980-1981 and 2000-2001. The percentage of medical students who were women also increased dramatically over this same period. In 1980-1981, females accounted for slightly more than one quarter of medical students; by 2000-2001, this proportion had increased to 44.6 percent. Women outnumbered men in U.S. schools of pharmacy and public health in 2000-2001.

As women have increased their representation in health professional schools that have traditionally been dominated by men, their concentration has decreased in nursing, a field that has been and continues to be made up almost entirely of women. While the numbers of students enrolled in nursing schools increased over the past two decades, the percentage of nursing students who were women declined from 94.3 percent in 1980-1981 to 90.3 in 2000-2001, reflecting men's increasing role in the nursing profession.

Women in Schools for Selected Health Professions, 1980-1981 and 2000-2001
Source (I.4): Professional Associations



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WOMEN IN THE LABOR FORCE

As the proportion of U.S. women in the labor force continues to increase, so does their representation in various occupational sectors. In 2001, women made up 46.5 percent of the labor force. The occupational sectors with the highest representation of women included sales and office occupations (63.7 percent) and service occupations (56.7 percent).

Although women may be making strides in terms of equal employment with men, only 29.0 percent of those who earned between $50,000-$99,999 were women, and an even smaller proportion of those who earned over $100,000 were women (17.1 percent). Furthermore, women earned only 76 cents for every dollar that men earned in 2001.[1]

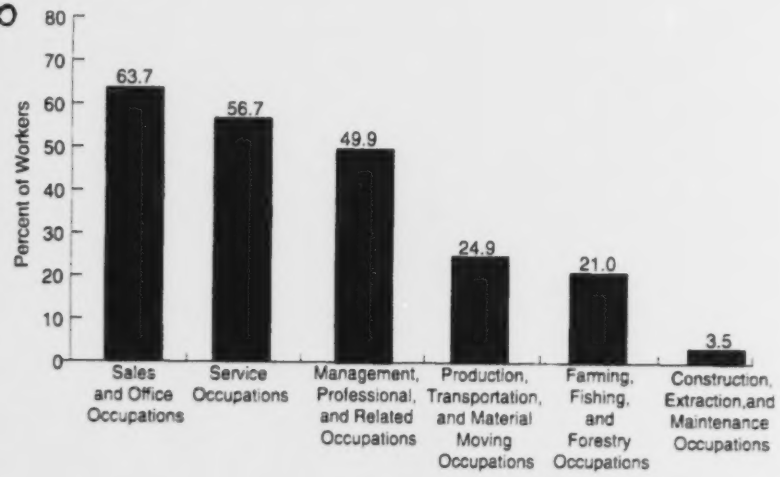
With 60.9 million women in the work force, their health and safety is critical to America's productivity. In 2000, 555,722 women sustained a non-fatal occupational injury. Women working in sales/administrative support and service occupations had the highest percentages of injuries (23.8 and 32.4 percent respectively). Nearly half (47.5 percent) of all non-fatal injuries included sprains, strains, or tears to a muscle, tendon, ligament, or joint.[2] In addition to physical risks, one study showed that 60 percent of women reported that stress was their most significant problem at work.[3]

1U.S. Department of Labor. Bureau of Labor Statistics. Labor Force Statistics for the Current Population Survey. Median Weekly Earnings. http://stats.bls.gov/cps/cpsaat37.pdf

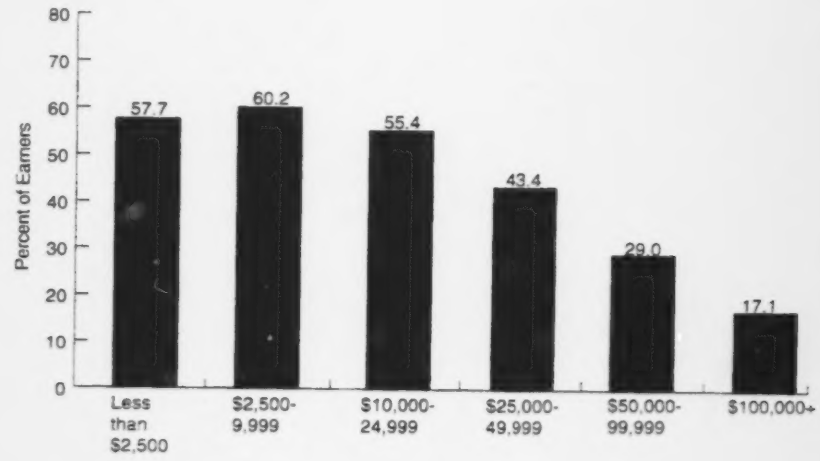
2U.S. Department of Labor. Bureau of Labor Statistics. Injuries, Illnesses, and Fatalities, Table R43 and R47. http://stats.bls.gov/iif/oshcdnew.htm#Resource%20Table%20categories%20-%202000

3National Institute for Occupational Safety and Health, "Women's Safety and Health Issues at Work." Centers for Disease Control and Prevention, NIOSH. Cincinnati, OH, 2001. http://www.cdc.gov/niosh/01-123.html.

Distribution of Women Aged 16 and Older in Occupational Sectors, 2001
Source (I.1): U.S. Census Bureau



Distribution of Women Aged 16 and Older Across Earning Levels, 2001
Source (I.1): U.S. Census Bureau



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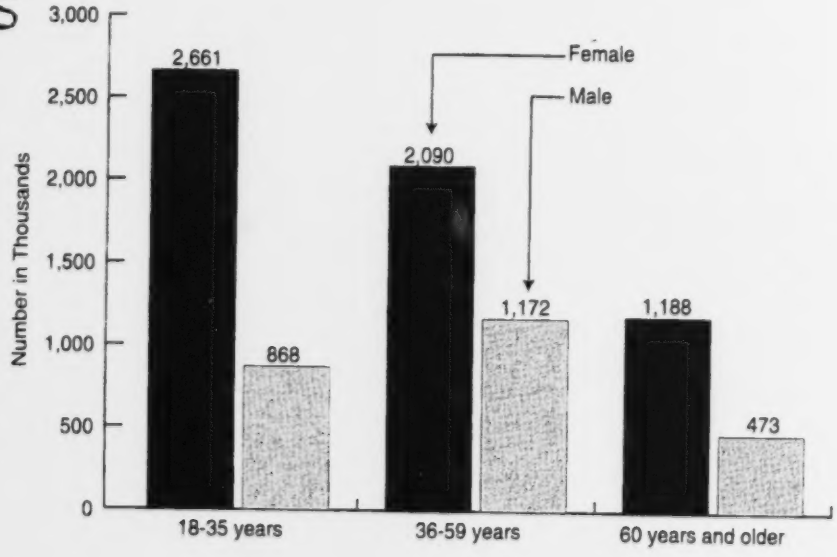
WOMEN AND FEDERAL PROGRAM PARTICIPATION

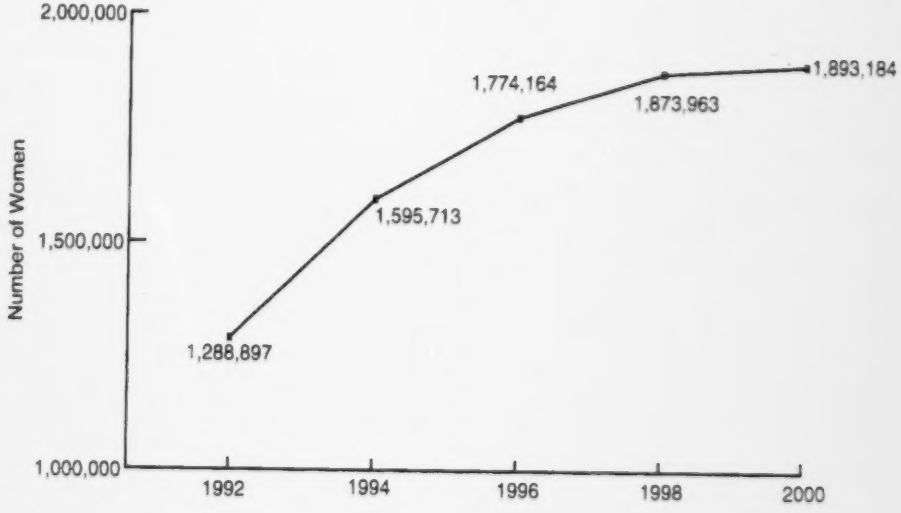
Federal food and nutrition assistance programs serve many women in the U.S. The Federal Food Stamp program helps low-income individuals purchase nutritious foods. In 2001, 70.3 percent of all adult Food Stamp program participants were females. The largest percent of women participants were aged 18-35 (44.8 percent).

The Supplemental Food Program for Women, Infants, and Children (WIC) also plays an important role in serving women by providing supplementary nutrition during pregnancy, the postpartum period, and while breastfeeding. From 1992 to 2000, the number of adult women participating in WIC increased by 47 percent, from approximately 1.3 million participants in 1992 to nearly 1.9 million in 2000.

Adult Recipients of Food Stamps, by Age, 2001
Source (I.5): U.S. Department of Agriculture



Women WIC Participants, Selected Years 1992-2000
Source (I.6): U.S. Department of Agriculture



WOMEN AND FEDERAL PROGRAM PARTICIPATION (Cont'd)

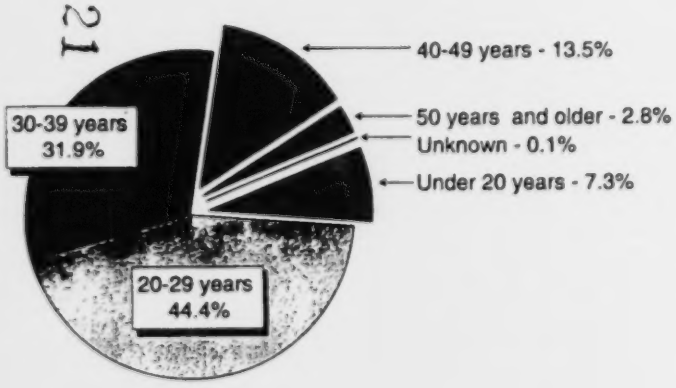
Temporary Assistance to Needy Families (TANF) is the Federal-and-State funded program that provides cash assistance and work opportunities to needy families. In 1996, TANF replaced the national welfare program known as Aid to Families with Dependent Children (AFDC) and related initiatives known as the Job Opportunities and Basic Skills Training (JOBS) program and the Emergency Assistance (EA) program. The overarching goals of TANF are to move recipients into work and turn welfare into a program of temporary assistance with a lifetime maximum allowance of 5 years.

In Fiscal Year 2000, adult TANF recipients numbered 1.6 million, of whom 1.4 million were women (90 percent). Females using the TANF program were largely dominated by young and middle-aged women, with three-quarters of adult female recipients between 20 and 39 years of age. Among adult female TANF recipients, nearly 27 percent were employed (compared to 25.1 percent of male recipients), 49.3 percent were not employed, and the remaining 24.2 percent were not in the labor force.

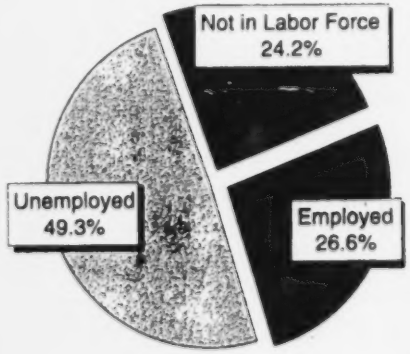
In 2000, the average amount of monthly assistance provided through TANF was $349. Some TANF families with children who were not employed also received assistance in the form of child care and transportation. Of TANF families who were employed, the average monthly non-TANF income was $580.

Supplemental Security Income (SSI) is another public assistance program that provides support to low-income and disabled persons. In 2001, 61.6 percent of adults receiving federally-administered SSI payments were women. The majority of adult females receiving SSI payments were under age 65.

Female Recipients of TANF, by Age, Fiscal Year 2000
Source (I.7): Administration for Children and Families



Female Recipients of TANF, by Employment Status, Fiscal Year 2000
Source (I.8): Administration for Children and Families



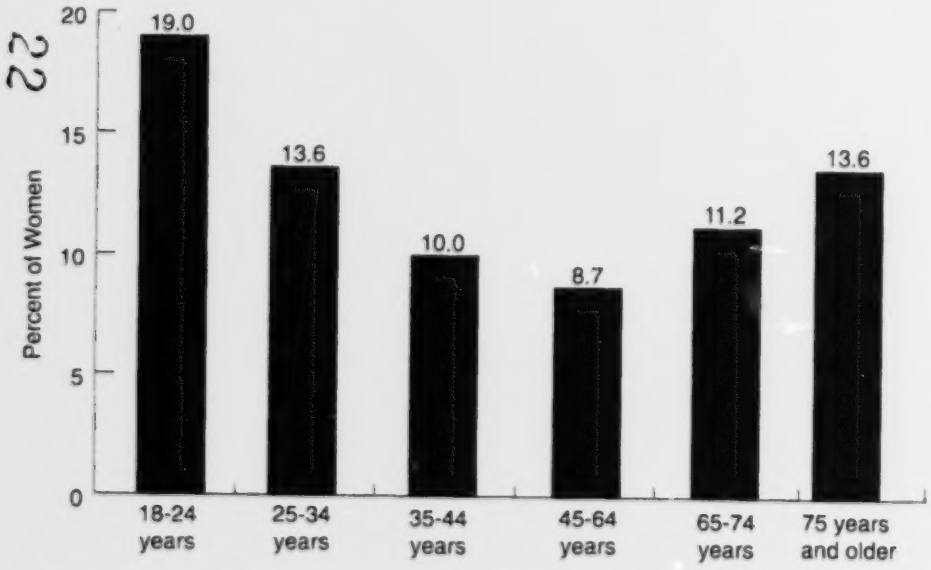
WOMEN AND POVERTY

In 2001, 12.8 million women and 8.4 million men aged 18 and older were living with incomes below the Federal poverty level.[1] Women aged 18-24 were most likely to be poor, with a poverty rate of 19.0 percent. The percentage of females under the Federal poverty level declines after women reach age 65. In 2001, the lowest poverty rate was among women aged 45-64 (8.7 percent). The poverty rate then increased for women aged 65 and older to 11.2 percent and 13.6 percent for women aged 75 and older.

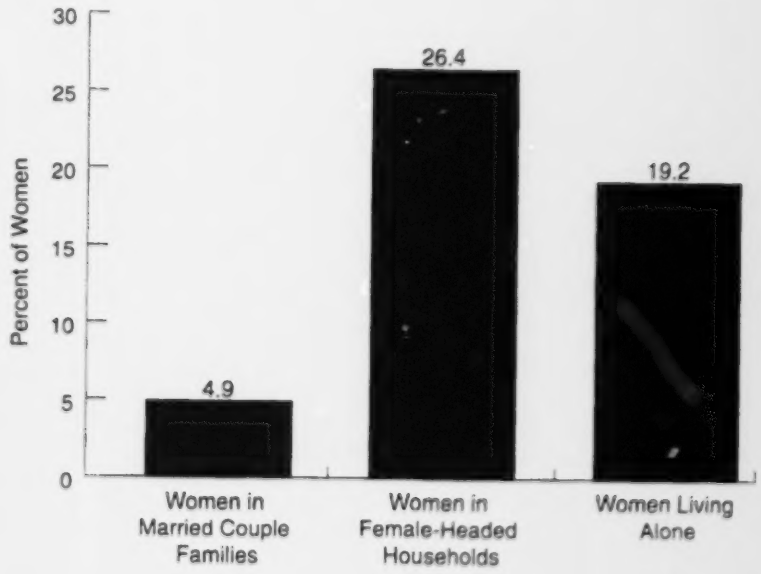
Among selected household types, women heading households with no spouse had the highest rates of poverty (26.4 percent), followed by females living alone (19.2 percent). The poverty rate for women living in married couple families was much lower (4.9 percent).

1The Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who is poor. If a family's total income is less than that family's threshold, then that family and every individual in it is considered to be poor. Examples of 2001 poverty levels were $9,039 for an individual, $11,569 for a family of two, $14,128 for a family of three, and $18,104 for a family of four.

Women Living Below the Poverty Level, by Age, 2001
Source (1.9): Current Population Survey



Women Living Below the Poverty Level, by Household Type, 2001
Source (1.9): Current Population Survey



HEALTH STATUS

The systematic assessment of women's health status enables health professionals and policy makers to determine the impact of past and current health interventions and the need for new programs. Trends in health status help to identify new issues as they emerge.

In the following section, health status indicators are presented related to mortality, health behaviors, morbidity, and reproductive health. Issues pertinent to selected populations of women, including older, immigrant, rural, and incarcerated women are also addressed. The data are displayed by gender, age, and race and ethnicity, where available.

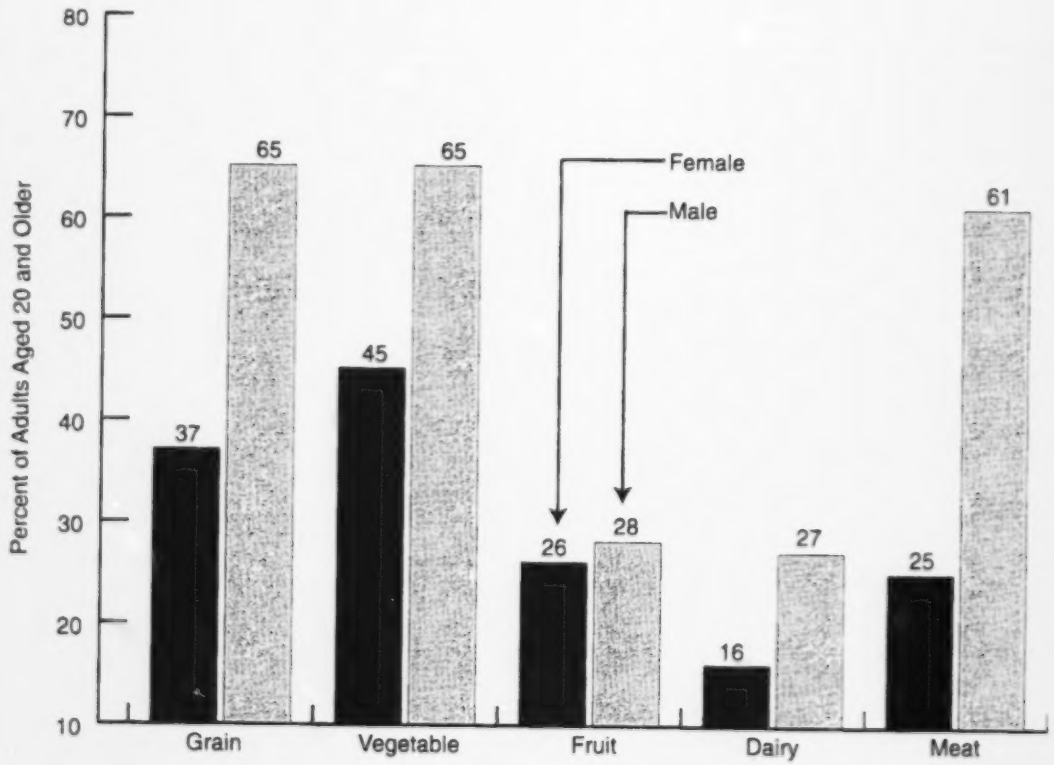
NUTRITION

The U.S. Department of Agriculture's (USDA) Food Guide Pyramid provides dietary guidelines for individuals aged 2 years and older on daily nutritional intake and reducing excessive fat consumption. According to the Food Guide Pyramid, everyone should eat at least the minimum number of servings within the recommended ranges, which are 6-11 grain servings, 3-5 vegetable servings, 2-4 fruit servings, 2-3 dairy servings, and 5-7 ounces of meat. The number of servings that is right for a person may vary depending on their caloric needs, age, physical activity level, and whether a woman is pregnant or lactating.

During 1994-1996, the majority of women aged 20 and older did not consume the daily recommended servings for any of the food groups in the Food Guide Pyramid. Women were more likely (45 percent) to consume the recommended servings for the vegetable group and less likely (16 percent) to consume the recommended servings of dairy, which is an important source of calcium. However, men were more likely than women to consume the recommended amounts of all food groups.

Adults Aged 20 and Older Who Consumed the Recommended Servings* of Food Groups, by Sex, 1994-1996

Source (II.1): Continuing Survey of Food Intakes by Individuals



*Recommended servings were derived from "The Food Guide Pyramid," based on at least 6 servings of grains, 3 servings of vegetables, 2 servings of fruit, 2 servings of dairy, and 5 ounces of meat per day when an individual consumed 2,200 to 2,800 calories. Consumption of servings was averaged over a 2-day period.

VITAMIN AND MINERAL SUPPLEMENT USE

Vitamin and mineral supplement use is of particular interest for the health of women. There are specific circumstances during a woman's life cycle which are associated with special vitamin and mineral supplement needs (e.g. the period prior to conception, during pregnancy, and when at risk for certain health conditions such as osteoporosis).

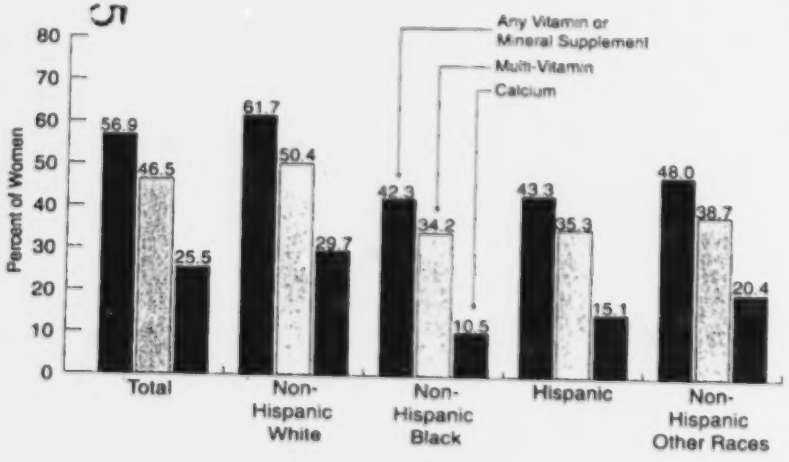
In 2000, 56.9 percent of U.S. women took at least one type of a vitamin or mineral supplement during the year. Non-Hispanic White women reported the highest proportion of supplement use (61.7 percent). In general, the use of vitamin and mineral supplements increased with age. In 2000, 64.6 percent of women aged 65-84 reported using any vitamin or mineral supplement compared to 43.8 percent of women aged 18-24, although use declined among women aged 85 and older.

Calcium is necessary for building and maintaining strong and healthy bones. The National Academy of Sciences recommends that adults aged 19-50 years get 1,000 mg of calcium per day and adults aged 51 and older get 1,200 mg per day.[1] Women may take a calcium supplement if they do not think they are meeting this recommendation by eating calcium rich foods such as milk, cheese, and yogurt. In 2000, 25.5 percent of women took a calcium supplement. Women aged 65-84 reported the highest percent of calcium supplement use (37.5 percent).

1Standing Committee on the Scientific Evaluation of Dietary Reference Intakes, Food and Nutrition Board, Institute of Medicine. Dietary Reference Intakes For Calcium, Phosphorus, Magnesium, Vitamin D, and Fluoride. Table S1. http://www.nap.edu/html/dri_calcium/tables.html

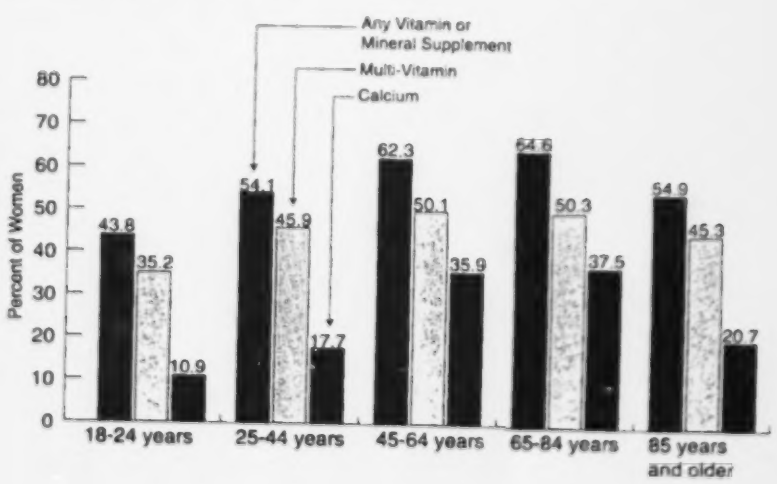
Vitamin and Mineral Supplementation Among Women Aged 18 and Older, by Race/Ethnicity, 2000

Source (II.2): National Health Interview Survey



Vitamin and Mineral Supplementation Among Women Aged 18 and Older, by Age, 2000

Source (II.2): National Health Interview Survey



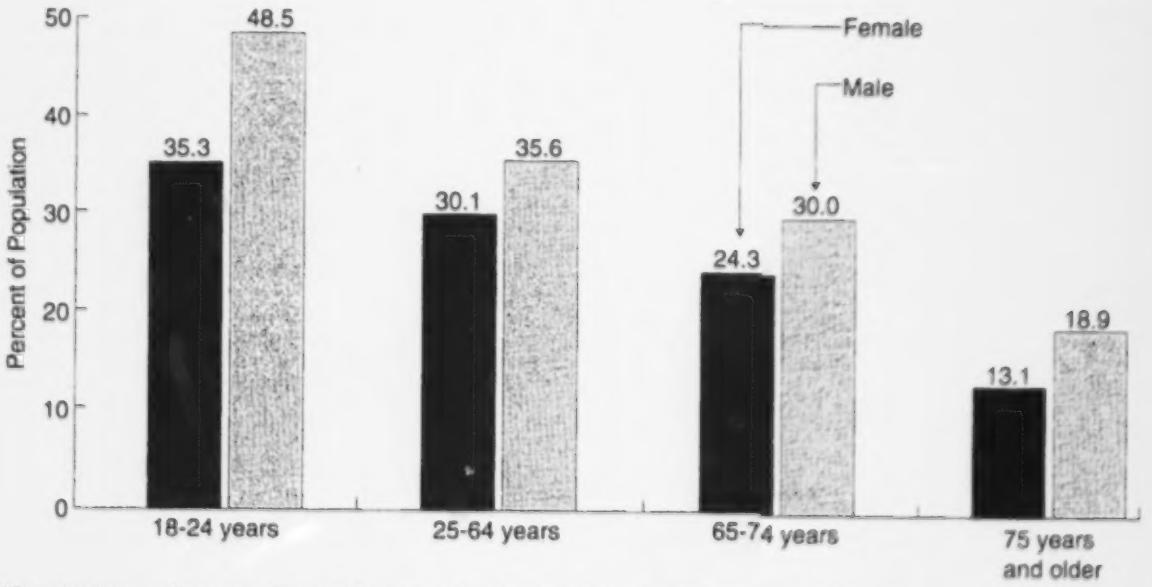
PHYSICAL ACTIVITY

Health professionals recommend regular physical activity to improve wellness and reduce risk of disease. Physical inactivity is a significant problem among U.S. adults, contributing to a host of health risk factors and health conditions including obesity, hypertension, heart disease, diabetes, and cancer.

Among all age groups, men were more likely than women to participate in regular physical activity. The largest disparity between males and females was among adults aged 18-24, of whom 35.3 percent of women and 48.5 percent of men reported engaging in regular physical activity. Rates decreased for both men and women with advancing age; only 13.1 percent of women and 18.9 percent of men aged 75 and older reported being physically active.

Adults Who Engaged in Regular Leisure-Time Physical Activity,* by Age and Sex, 2001

Source (II.3): National Health Interview Survey



*Regular leisure-time physical activity was defined as engaging in light-moderate leisure-time physical activity for greater than or equal to 30 minutes 5 or more times per week or engaging in vigorous leisure-time physical activity for greater than or equal to 20 minutes 3 or more times per week.

CIGARETTE SMOKING

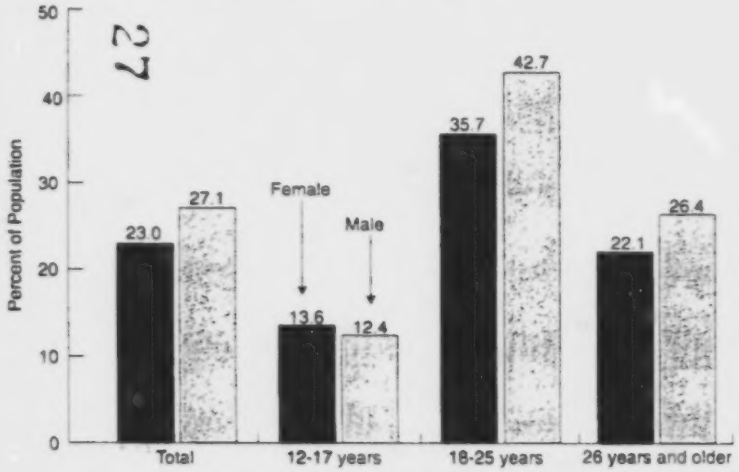
The percentage of women who smoke, a behavior associated with numerous chronic illnesses, has remained steady over the last several years at slightly more than 20 percent of women aged 18 and older.[1] In 2001, 23.0 percent of females aged 12 and older reported smoking cigarettes within the past month. Among adolescents aged 12-17, slightly more females than males reported smoking in the past month (13.6 percent versus 12.4 percent). However, women aged 18 years and older were less likely than men to have smoked in the previous month. For both sexes combined, cigarette smoking was most prevalent among young adults aged 18-25 and decreased with increasing age to 9.1 percent of individuals aged 65 and older.

Among females who were not pregnant, American Indian/Alaska Native women were most likely to smoke in 2000-2001, followed by non-Hispanic White women. Although the prevalence of smoking was lower among pregnant women in all racial and ethnic groups, non-Hispanic White women were more than twice as likely to smoke during pregnancy than non-Hispanic Black women. There was a slight increase in recent years in the proportion of pregnant women who reported cigarette smoking in the past month, from 18.6 percent in 1999-2000 to 19.8 percent in 2000-2001. Maternal smoking during pregnancy is associated with ectopic pregnancies, miscarriages, low birth weight, and infant mortality.

1National Center for Health Statistics (2002). Health, United States. Hyattsville, Maryland: DHHS (Table 61).

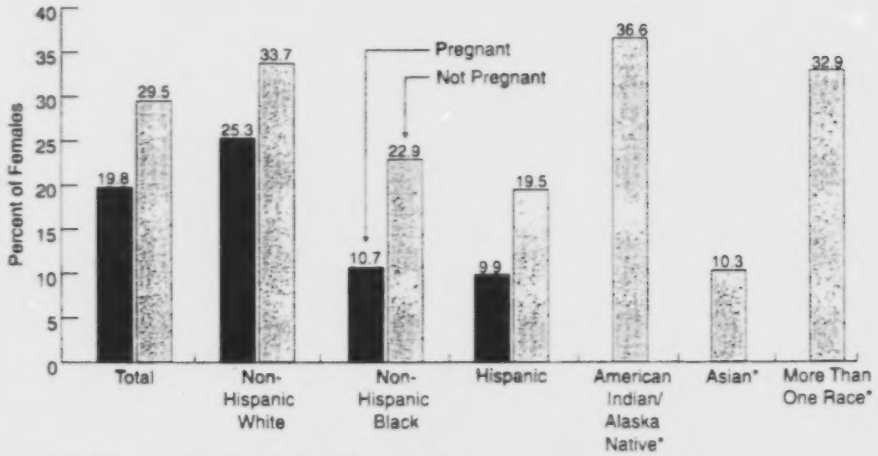
Persons Reporting Past Month Use of Cigarettes, by Age and Sex, 2001

Source (II.4): National Household Survey on Drug Abuse



Females Aged 15-44 Years Reporting Past Month Use of Cigarettes, by Race/Ethnicity and Pregnancy Status, 2000-2001

Source (II.4): National Household Survey on Drug Abuse



**Low precision, no estimate for pregnant women reported*

ALCOHOL MISUSE

In 2001, 13.4 percent of females and 28.2 percent of males aged 12 and older reported binge alcohol use in the past month, defined as having five or more drinks on the same occasion at least once in the month prior to the survey. Additionally, 2.6 percent of females and 9.2 percent of males 12 years and older reported heavy alcohol use in the past month, defined as having five or more drinks on the same occasion on five or more days within the month prior to the survey.

Alcohol misuse appears higher among young adult women than among their younger and older counterparts. Among women 18-25 years old in 2001, 29.2 percent reported binge drinking in the past month, and 7.7 percent of women in this age group reported drinking heavily. Females in other age groups reported lower rates of both binge and heavy drinking. After age 25, binge and heavy alcohol consumption declined significantly for both males and females.

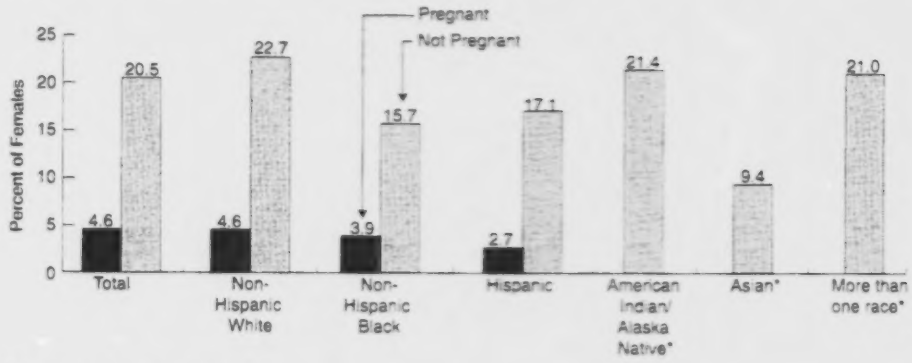
Among women aged 15-44 who were not pregnant, non-Hispanic White and American Indian/Alaska Native women were the most likely to be binge drinkers (22.7 percent and 21.4 percent, respectively) compared to other racial/ethnic groups. Non-Hispanic White women were also the most likely to engage in binge alcohol use during pregnancy. Drinking alcohol during pregnancy contributes to Fetal Alcohol Syndrome (FAS), infant low birth weight, and developmental delays in children.

Persons Reporting Past Month Alcohol Use and HeavyAlcohol Use, by Age and Sex, 2001**

Source (II.4): National Household Survey on Drug Abuse

Females Aged 15-44 Years Reporting Past Month Binge Alcohol Use, by Race/Ethnicity and Pregnancy Status, 2000-2001**

Source (II.4): National Household Survey on Drug Abuse



*Low precision, no estimate reported.

**"Binge" Alcohol Use was defined as drinking five or more drinks on the same occasion on at least 1 day in the past 30 days. "Occasion" means at the same time or within a few hours of each other. "Heavy" Alcohol Use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days; all "Heavy" Alcohol Users are also "Binge" Alcohol Users.

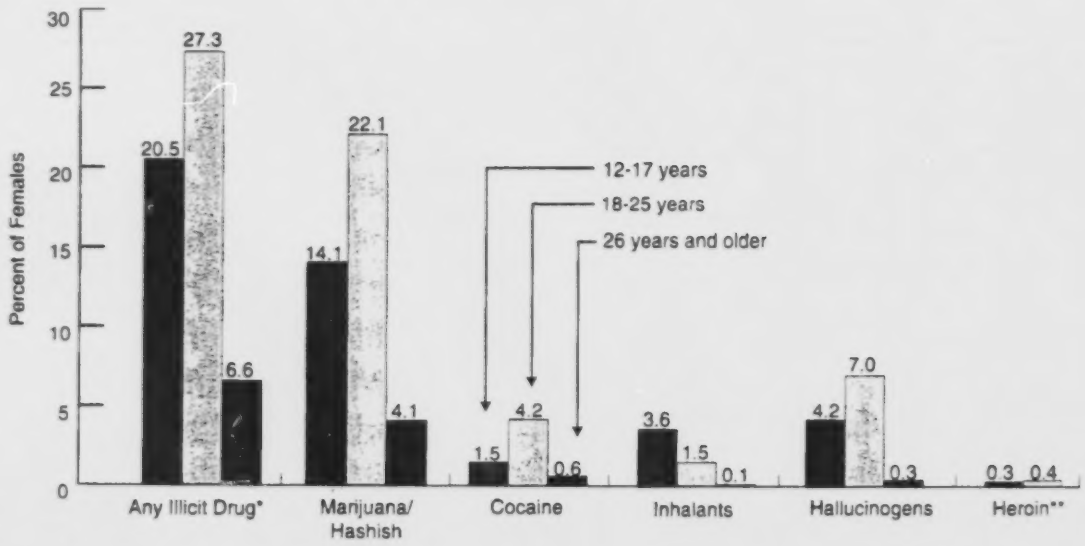
ILLICIT DRUG USE

Because of their potential risk for misuse and addiction, marijuana/hashish, cocaine, inhalants, hallucinogens, heroin, and prescription-type psychotherapeutic drugs used for non-medical purposes are classified as illicit drugs in the U.S. In 2001, 27.3 percent of women aged 18-25 and 20.5 percent of females aged 12-17 had used some type of illicit drug within the past year. Marijuana/hashish was reported as the leading illicit drug used by women of all ages. Over one-fifth of women aged 18-25, 14.1 percent of females aged 12-17, and 4.1 percent of women 26 and older reported using marijuana/hashish in the past year. The 18-25 age group was also more likely to use cocaine and hallucinogens.

Inhalant use was most frequently reported by females aged 12-17. With the exception of inhalant drugs, the proportion of women who used illicit drugs increased from the teen years to the mid-twenties and then decreased among women aged 26 and older.

Females Reporting Past Year Use of Illicit Drugs, by Age and Drug Type, 2001

Source (II.4): National Household Survey on Drug Abuse



*Any illicit drug includes marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or any prescription-type psychotherapeutic used for non-medical purposes.

**Data for use of heroin not available for females aged 26 years and older.

SELF-REPORTED HEALTH STATUS

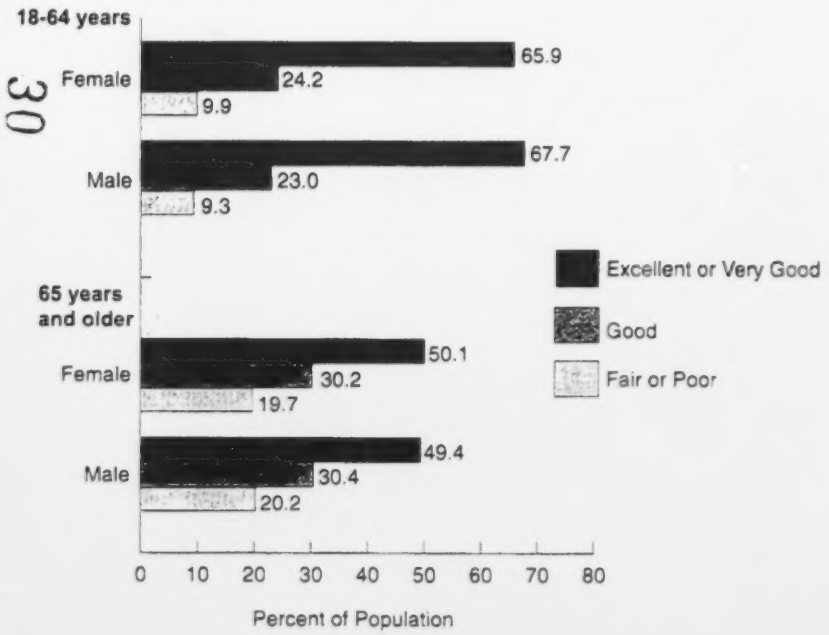
In 2001, nearly two-thirds of women and men reported being in excellent or very good health. For both men and women, the percent reporting their health as excellent or very good declined significantly with age. While 65.9 percent of females between the ages of 18 and 64 reported their health as excellent or very good, only 50.1 percent of females aged 65 and older did so.

More than half of women in all racial and ethnic groups reported being in excellent or very good health, although a greater proportion of non-Hispanic White and Hispanic females rated their health as excellent or very good than Non-Hispanic Black women. Non-Hispanic Black women were most likely to report being in fair or poor health. Women of other races[1] were the most likely to report being in excellent or very good health (65.3 percent) and the least likely to report being in fair or poor health (10.0 percent).

1Other races may include Asian/Pacific Islander, American Indian/Alaskan Native or multiracial.

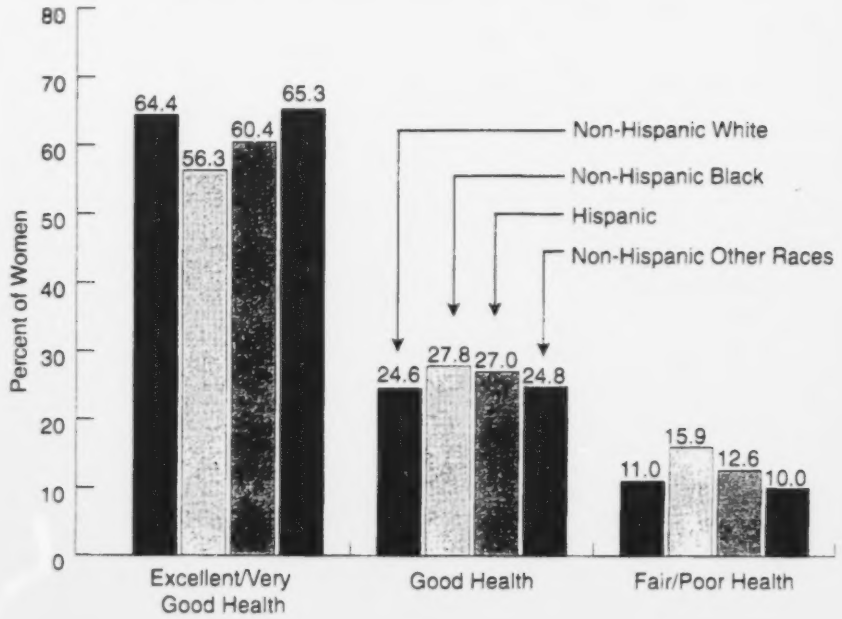
Self-Reported Health Status of Adults Aged 18 and Older, by Age and Sex, 2001

Source (II.3): National Health Interview Survey



Self-Reported Health Status of Women Aged 18 and Older, by Race/Ethnicity, 2001

Source (II.3): National Health Interview Survey



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ACTIVITY LIMITATIONS

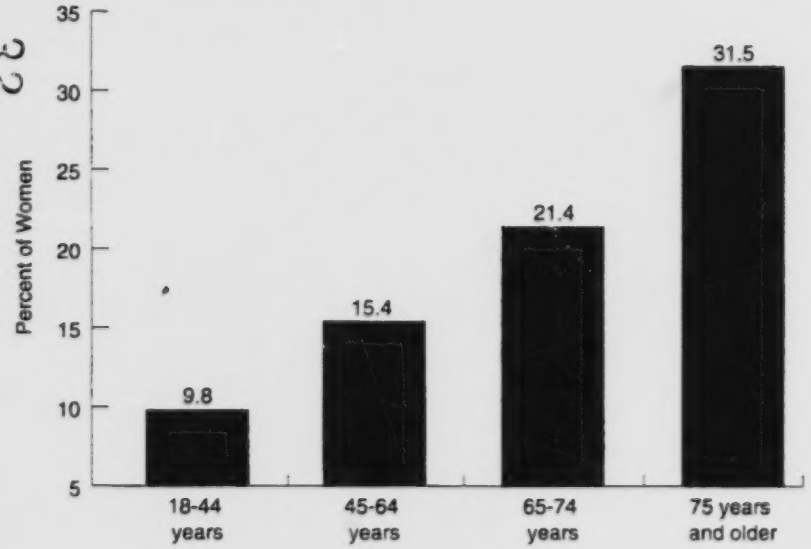
Women's likelihood of experiencing activity limitations[1] increases with age. In 2001, women aged 45-64 were nearly twice as likely to report an activity limitation as females aged 18-44. Females aged 65-74 and 75 years and older had the highest rate of activity limitations (21.4 and 31.5 percent, respectively).

The four conditions most frequently reported by women in 2001 as the cause of an activity limitation included arthritis/rheumatism (25.5 percent), back/neck problems (20.4 percent), heart problems (14.0 percent), and hypertension (12.9 percent). Women's activities were not only limited by physical impairments; 11.7 percent of women cited depression, anxiety, or other mental health problems as the cause of their activity limitations.

1An activity limitation is defined as being limited in any way in any activities because of a physical, mental, or emotional problem.

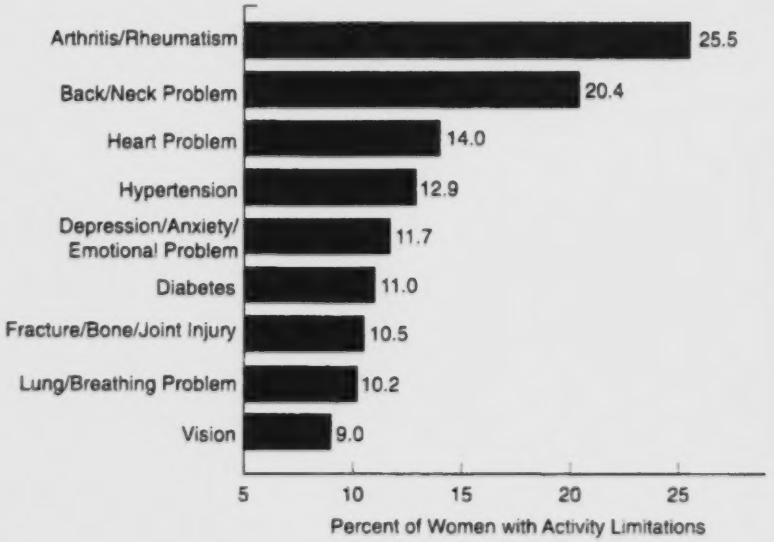
Self-Reported Activity Limitations of Women Aged 18 and Older, by Age, 2001

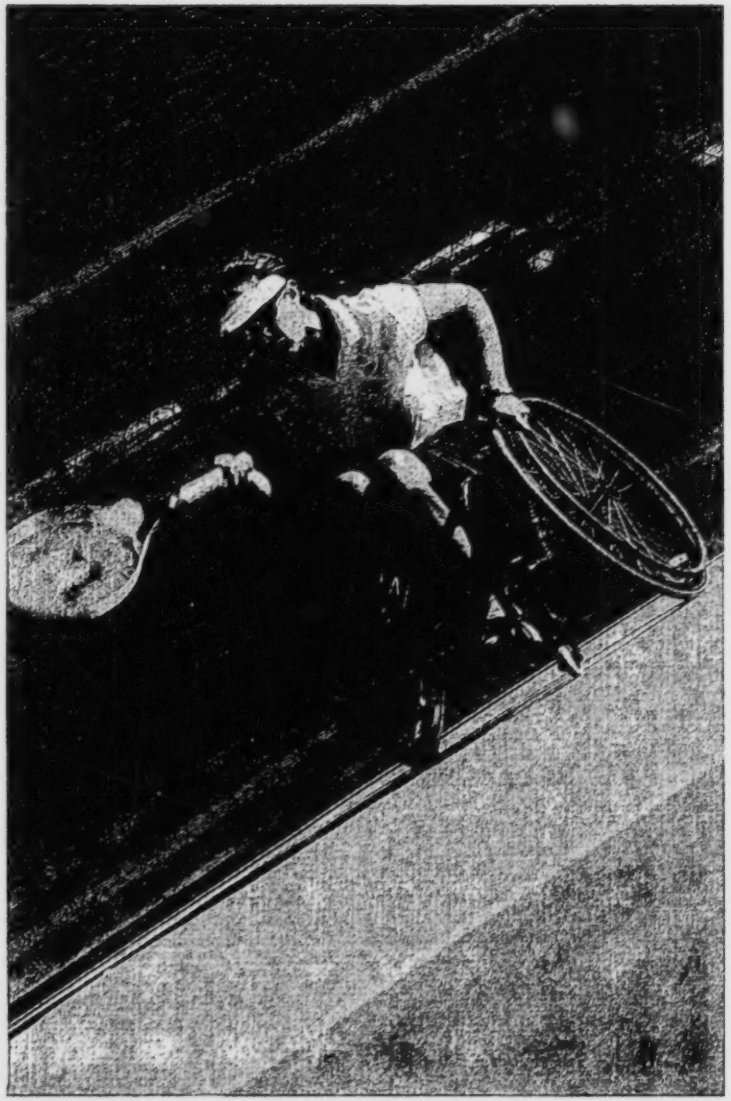
Source (II.3): National Health Interview Survey



Conditions Causing Activity Limitations in Women Aged 18 and Older, 2001

Source (II.3): National Health Interview Survey





AIDS

Although Acquired Immunodeficiency Syndrome (AIDS) was primarily diagnosed in men in the early 1980s, by the 1990s the disease had become more prevalent among women. In 1993, the Centers for Disease Control and Prevention expanded the criteria for AIDS cases to include persons with severe immunosuppression, pulmonary tuberculosis, recurrent pneumonia, or invasive cervical cancer.[1] This had the effect of greatly increasing the number of reported AIDS cases.

In 2001, 25.8 percent (11,082 cases) of all reported U.S. AIDS cases among those aged 13 years and older occurred in females. AIDS cases among these females were attributed to two major exposure categories: heterosexual contact and injecting drug use. Undetermined modes of transmission accounted for another 4,606 cases.

AIDS cases due to heterosexual contact and injecting drug use were highest among non-Hispanic Black women in 2001 (2,606 and 1,257 cases, respectively). Non-Hispanic Black women represented 63 percent of all AIDS cases in women attributable to heterosexual contact and 57 percent of AIDS cases among women attributable to injecting drug use.

1Centers for Disease Control and Prevention, 1993. Impact of the Expanded AIDS Surveillance Case Definition on AIDS Case Reporting-United States, First Quarter, 1993. MMWR, April 30, 1993. 42(16); 308-310.

AIDS Cases, by Selected Exposure Categories* for Females Aged 13 Years and Older at Diagnosis, Selected Years 1985-2001

Source (I1.5): Centers for Disease Control and Prevention

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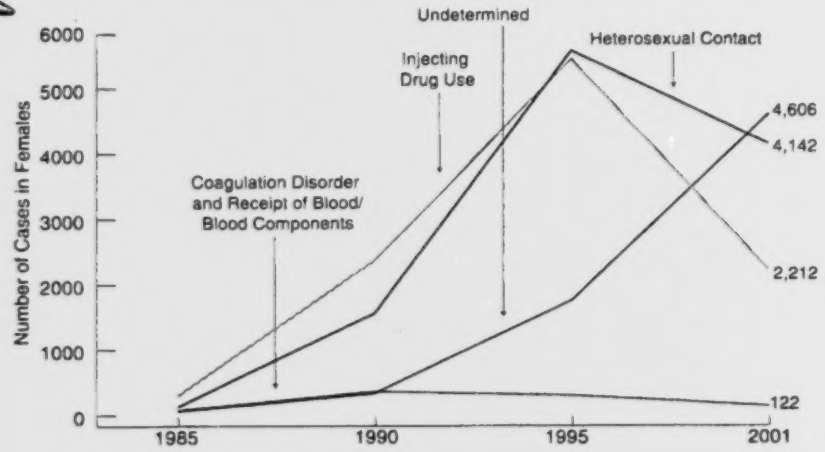
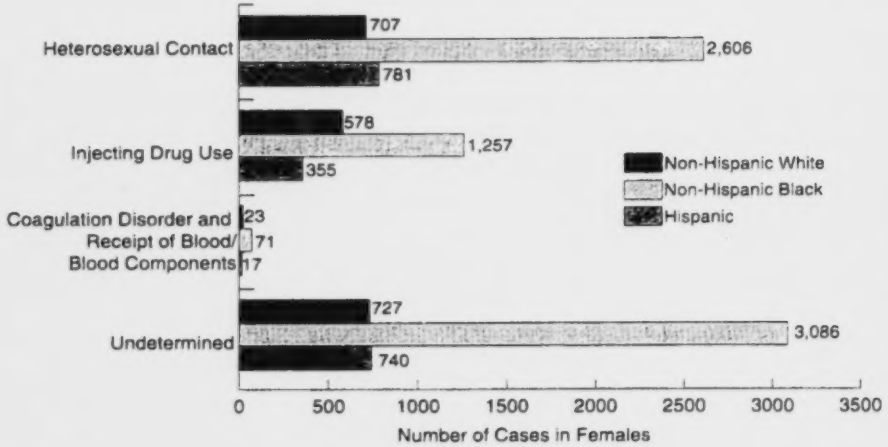


*Changes in reporting procedures in 1993 led to an increase in the number of cases reported without information about the exposure category.

Female Adult/Adolescent AIDS Cases, by Exposure Categories* and Race/Ethnicity, 2001

Source (I1.6): Centers for Disease Control and Prevention



*Number for Asian Pacific Islanders and American Indian/Alaska Natives is too small to illustrate on graph.

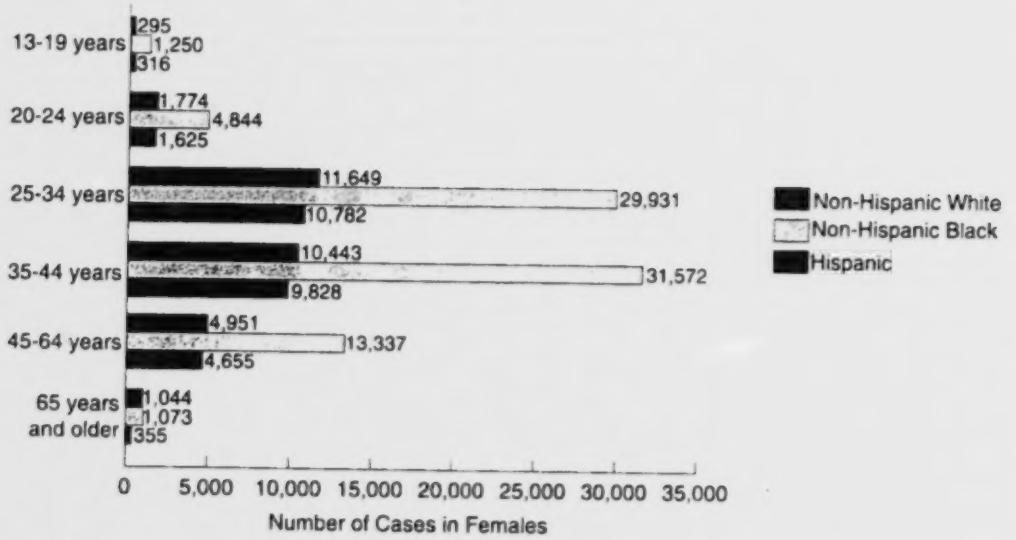
**Each reported case of AIDS is assigned to one exposure category, even if more than one risk factor is present, according to the probability of acquiring the infection from each risk behavior.

AIDS(Cont'd)

As of December 2001, a total of 141,048 cases of AIDS had been reported in adolescent and adult women in the U.S. The majority of reported AIDS cases among adolescent and adult women were among women aged 25-44 years. The largest number of reported AIDS cases in this age group was among non-Hispanic Black women.

Female AIDS Cases, by Age of Diagnosis and Race/Ethnicity, 2001

Source (II.6): Centers for Disease Control and Prevention

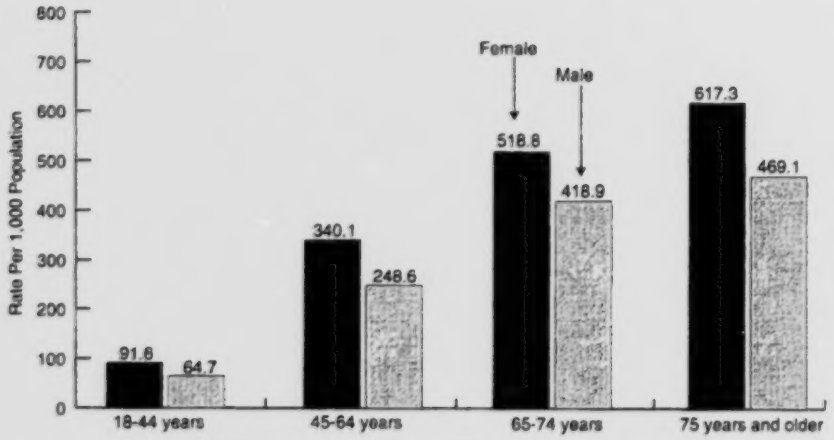


ARTHRITIS

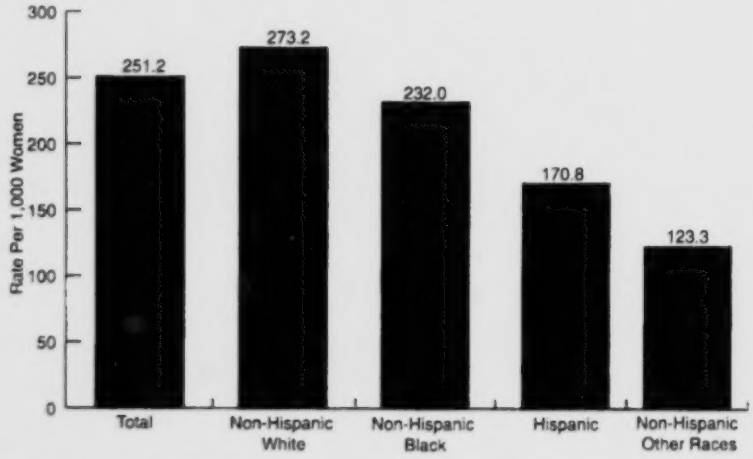
Arthritis is the leading cause of disability among women in the U.S. Characterized by an inflammation of the joints, rates of arthritis increase dramatically with age. In 2001, women reported higher rates of arthritis compared to men in every age group. The rate of arthritis was 91.6 per 1,000 population among women aged 18-44 as compared to 64.7 in men of this age group. For women aged 45-64, the rate of arthritis rose to 340.1 and to 617.3 for women aged 75 and older.

High rates of arthritis among non-Hispanic White women may be largely accounted for by the older age distribution of this population.

Adults Aged 18 and Older with Arthritis,* by Age and Sex, 2001
Source (II.3): National Health Interview Survey



Women Aged 18 and Older with Arthritis,* by Race/Ethnicity, 2001**
Source (II.3): National Health Interview Survey



*Reported a health professional has ever told them they have arthritis.

**Rates reported are crude rates, meaning that they are not adjusted for the different age distributions of these populations.

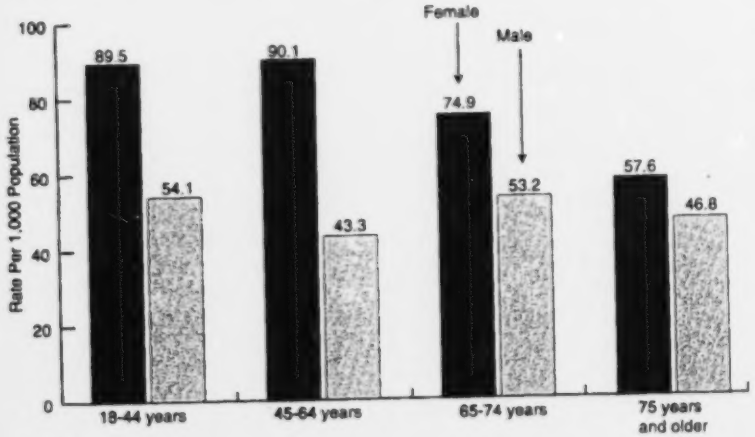
ASTHMA

Asthma is a chronic inflammatory disorder of the airways producing episodes of wheezing, chest tightness, shortness of breath, and coughing. Episodes are triggered by allergens, tobacco smoke and other irritants, exercise, and infections of the respiratory tract. With effective management, however, persons with asthma can enjoy normal activities of daily living.

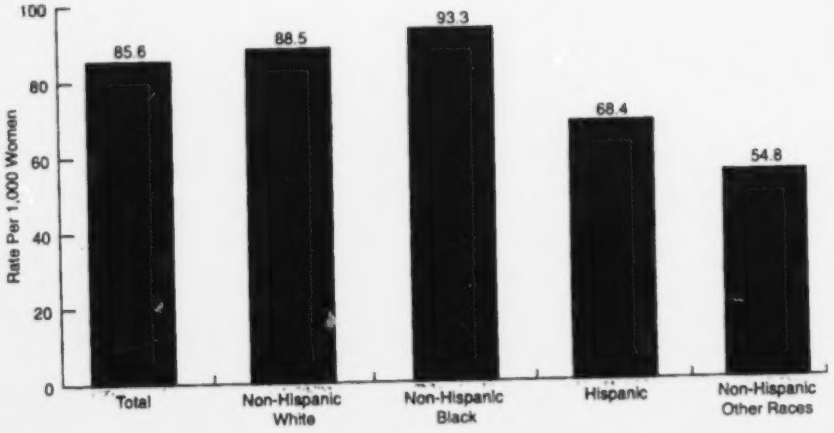
In 2001, women had higher rates of asthma than men. This disparity was the most pronounced among women aged 64 and younger, who experienced asthma at nearly twice the rate of men the same age.

Among U.S. women in 2001, non-Hispanic Black and non-Hispanic White females had the highest rates of asthma per 1,000 population (93.3 and 88.5, respectively), followed by Hispanic women (68.4) and other non-Hispanic women (54.8).

Adults with Asthma, by Age and Sex, 2001
Source (II.3): National Health Interview Survey



Women with Asthma,* by Race/Ethnicity, 2001**
Source (II.3): National Health Interview Survey



*Reported a health professional has ever told them they have asthma and report they still have asthma.

**Rates reported are crude rates, meaning that they are not adjusted for the different age distributions of these populations.

AUTOIMMUNE DISEASES

Autoimmune diseases include a diverse group of more than 80 chronic and often serious conditions that can affect nearly every organ system in the human body. In all of these diseases, the body's immune system harms its own healthy cells, tissues, and organs. Five major categories of autoimmune diseases exist: connective tissue diseases, including systemic lupus erythematosus and rheumatoid arthritis; neuromuscular diseases such as multiple sclerosis; endocrine diseases, including Hashimoto's thyroiditis and Graves' disease; gastrointestinal disorders such as Crohn's disease; and other autoimmune diseases primarily affecting the vascular system.

Approximately 75 percent of those affected by autoimmune diseases are women, most frequently during the childbearing years. Individually, autoimmune diseases are not very common, however, taken as a whole, they represent the fourth-largest cause of disability among women in the United States.[1]

One of the most common autoimmune diseases among women is systemic lupus erythematosus (SLE). SLE is characterized by the inflammation of connective tissues and can affect various parts of the body, including the joints, skin, and kidneys. Ninety percent of individuals diagnosed with the disease are women, and 80 percent of those afflicted with SLE develop it between the ages of 15 and 45.[2] Lupus is three times more common in Black women than White women and more common among women of Hispanic, Asian, and American Indian descent.[3]

1American Autoimmune Related Diseases Association, "Autoimmune Disease in Women - The Facts." http://www.aarda.org/women.html 1998-1999.

2Lupus Foundation of America. Lupus Fact Sheet. http://www.lupus.org/education/factsheet.html

3National Institute of Arthritis and Muscoloskeletal and Skin Diseases, National Institutes of Health. Handout on Health: Systemic Lupus Erythematosus. http://www.niams.nih.gov/hi/topics/lupus/slehandout/index.htm

BLEEDING DISORDERS

Bleeding disorders occur when blood platelets (blood cells) do not work correctly, which can hinder blood clotting and make it more difficult for the body to stop bleeding. The most common bleeding disorder among females is von Willebrand Disease (vWD). vWD affects up to 4 million Americans, half of whom are female.[1] Typical symptoms are heavy menstrual periods (menorrhagia), easy bruising, frequent nosebleeds, and prolonged bleeding after minor injuries, surgery, childbirth, or dental work.

The American College of Obstetricians and Gynecologists recommends that females who have heavy menstrual periods be screened for vWD, and that hysterectomy for menorrhagia should not be performed without testing for vWD.[2] A diagnosis of vWD requires taking a personal medical history, family medical history, and conducting laboratory tests. Effective treatments are available, allowing affected persons to live a normal life.

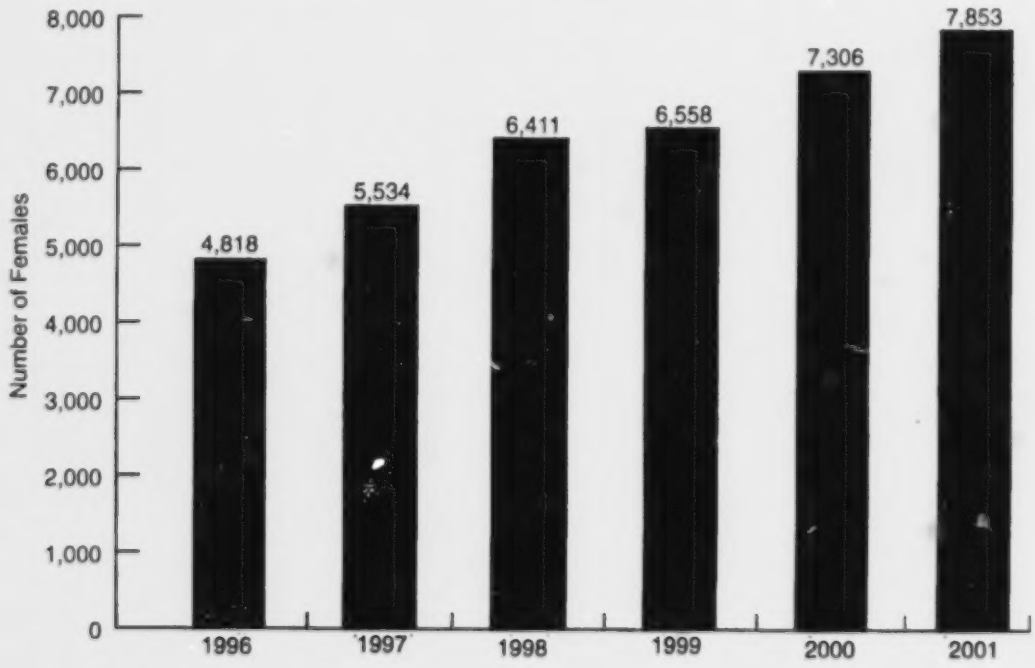
The 134 Federally-funded Hemophilia Treatment Centers are medical facilities with healthcare providers who are experts in diagnosing and treating bleeding disorders. From 1996 to 2001 the number of females enrolled in Hemophilia Treatment Centers increased from 4,818 to 7,853.

1Rodeghiero F, Castaman G, Dini E. Epidemiological investigation of the prevalence of Von Willebrand's Disease. Blood, 69:454-459. 1987.

2American College of Obstetricians and Gynecologists Committee Opinion No. 263 Von Willebrand Disease in Gynecologic Practice. Obstet Gynecol; 98;1185-1186. 2001.

Females (All Ages) with Bleeding Disorders Treated at Hemophilia Treatment Centers, 1996-2001

Source (II.7): Maternal and Child Health Bureau and Centers for Disease Control and Prevention



CANCER

In 2002, an estimated 267,300 females died of cancer in the U.S. Of these, it was estimated that lung/bronchus cancer caused 25 percent of cancer deaths, followed by breast cancer (15 percent) and cancer of the colon and rectum (11 percent).

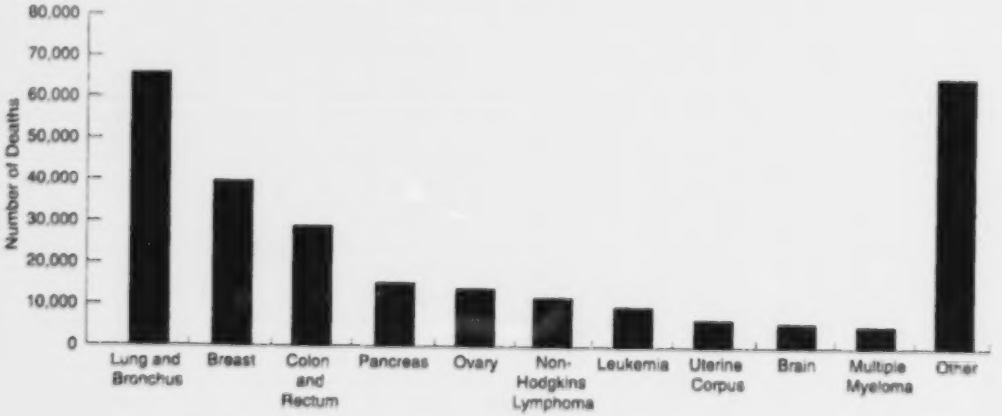
Cancer rates are tracked by the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program, which obtains data from 11 population-based registries and three supplemental registries covering approximately 14 percent of the U.S. population.[2] According to SEER data from 1992-1999, the rate of new cases of lung/bronchus cancer in females has remained stable from 48.7 cases per 100,000 population in 1992 to 48.2 in 1999. In 1999, Black and White women had the highest incidence rates of lung/bronchus cancer (55.7 and 49.9, respectively), with incidence rates that were at least twice those of Asian/Pacific Islander and Hispanic women. American Indian/Alaska Native women had the lowest cancer incidence rates; however, cancer remains the second leading cause of death among American Indian/Alaska Native women.[1]

1National Vital Statistics Report, Vol. 49, No. 11, October 12, 2001.

2In 2001, the registries were expanded to cover 26 percent of the

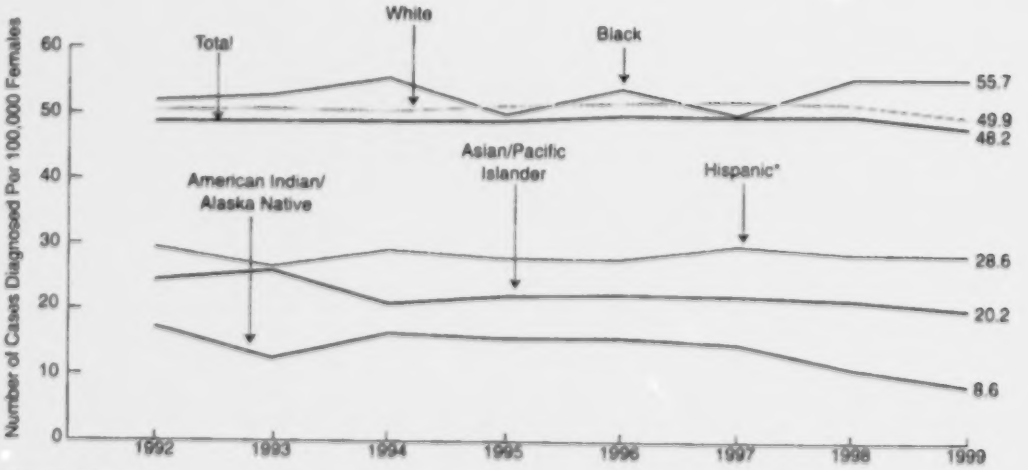
Leading Causes of Cancer Deaths for Females (All Ages), by Site, 2002 Estimates

Source (II.8): National Cancer Institute



Females With Lung and Bronchus Cancer, by Race/Ethnicity, 1992-1999

Source (II.9): National Cancer Institute



*May be of any race

40

CANCER (Cont'd)

From 1992 to 1999, the incidence rate of breast cancer among U.S. women increased nearly 5 percent, from 129.8 per 100,000 population in 1992 to 135.9 in 1999. Breast cancer increased among White and Asian/Pacific Islander females, while the rates among American Indian/Alaska Native, Hispanic and Black women remained relatively stable during this period. In 1999, White women had the highest incidence rates of breast cancer (140.8), followed by Black women (120.9).

The colon cancer rate for females overall declined slightly, from 47.9 in 1992 to 45.5 in 1999. American Indian/Alaska Native women had a major decrease in the incidence of colon/rectum cancer, while other racial groups had smaller decreases. In 1999, Black women had the highest incidence rates of colorectal cancer (56.1), followed by White (44.6) and Asian/Pacific Islander women (40.2).

Although death rates from colorectal and lung/bronchus cancers are higher than breast cancer death rates, breast cancer is more common among U.S. women. The rate of new cases of breast cancer (135.9) in 1999 was nearly three times higher than the incidence rates of lung/bronchus (48.2) and colon/rectum (45.5) cancers.

Health behaviors such as not smoking, being physically active, and eating a low-fat and nutritious diet may reduce the risk of cancer.[1] Screening for specific types of cancer in women is also recommended. Pap smears should begin three years after sexual activity begins, or at the age of 21, whichever comes first. Mammograms are recommended for women aged 40 years and older to screen for breast cancer and, for persons aged 50 and older, fecal occult blood testing and sigmoidoscopy are recommended to screen for colorectal cancer.[2] A recent study found that breastfeeding may also reduce the risk for premenopausal breast cancer and ovarian cancer.[3]

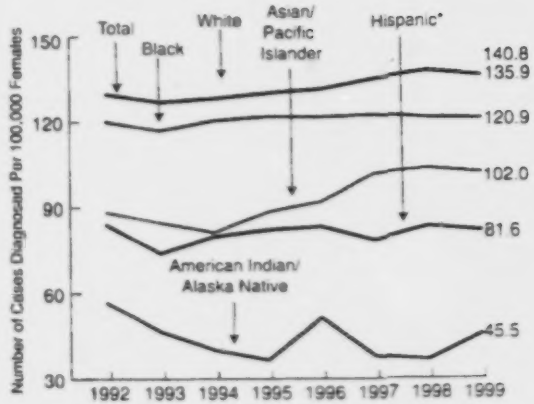
1United States Department of Health and Human Services. Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion. Chronic Diseases and Their Risk Factors. December 1999. http://www.cdc.gov/nccdphp/statbook/statbook.htm

2U.S. Preventive Services Task Force. Screening for Colorectal Cancer: Recommendations and Rationale. July 2002. Originally in Annals of Internal Medicine 2002; 137:129-31. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/clinic/3rduspstf/colorectal/colorr.htm

3Labbok MH. Effects of breastfeeding on the mother. Pediatric Clinics of North America 2001; 48(1):143-157.

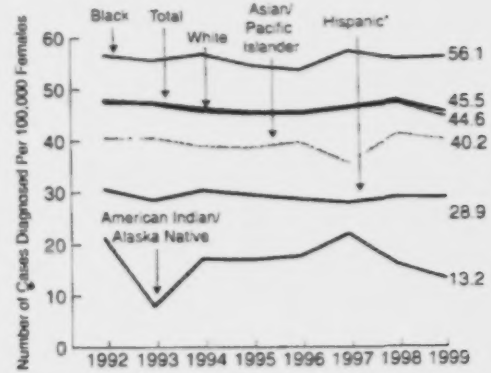
Females (All Ages) with Breast Cancer, by Race/Ethnicity, 1992-1999

Source (11.9): National Cancer Institute



Females (All Ages) with Colon and Rectum Cancer, by Race/Ethnicity,1992-1999

Source (11.9): National Cancer Institute



*May be of any race

DIABETES

Diabetes is a chronic condition and a leading cause of death and disability in the United States. Complications from diabetes include loss of vision, kidney failure, heart disease, limb amputations, and nerve damage, conditions which can both shorten the life span and diminish the quality of life.

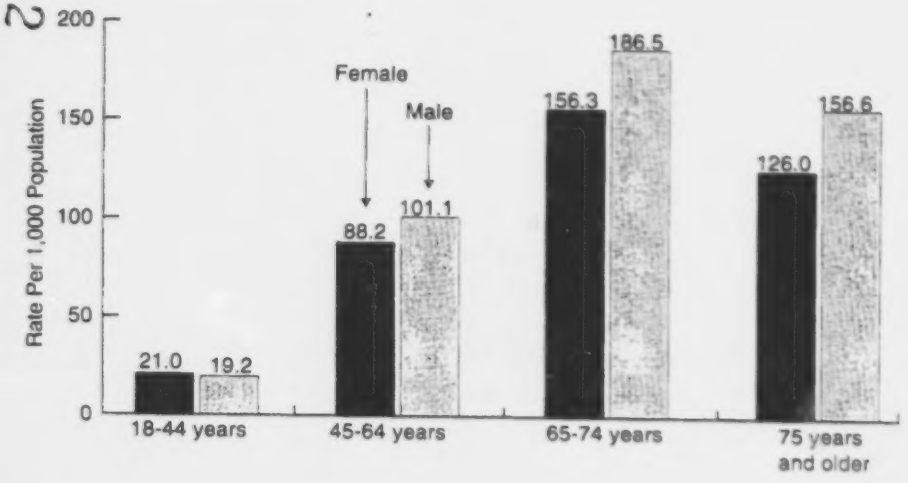
People may develop diabetes at any age. Of the two main types of diabetes, Type 1 diabetes is usually first diagnosed in children, teenagers, or young adults, and accounts for 5 to 10 percent of all diagnosed cases of diabetes. Type 2 diabetes can develop at any age and accounts for more than 90 percent of all diagnosed cases of diabetes. The risk for Type 2 diabetes may increase with age, obesity, and physical inactivity.1

In 2001, the rates of diabetes increased with age among both men and women. Compared to women aged 18-44, the rate of diabetes is more than four times higher in women aged 45-64 and more than seven times higher in women aged 65-74. Among adults aged 44 and younger, the rate of diabetes is slightly higher among females than males. However, this trend is reversed in adults aged 45 and older, where men exhibit higher rates of the disease.

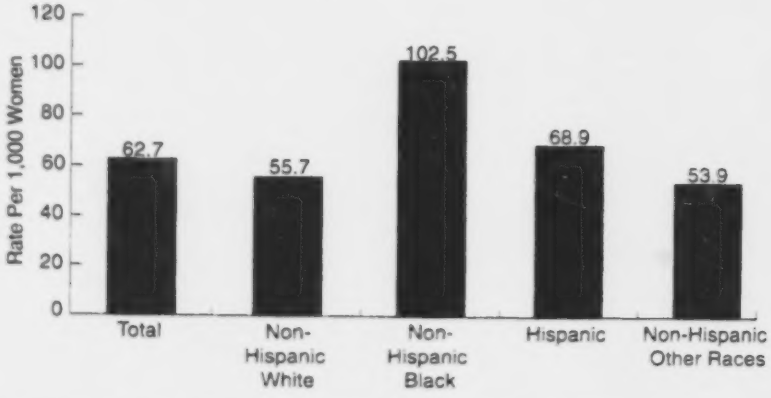
Although the rates are not age-adjusted, non-Hispanic Black women were more likely than women of other racial and ethnic groups to have diabetes. In 2001, the rate of non-Hispanic Black women was nearly twice the rate for non-Hispanic White women (102.5 compared to 55.7) and 1.5 times the rate for Hispanic women.

1Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion. Diabetes Public Health Resource.
http://www.cdc.gov/diabetes/faqs.htm#whatis

Adults Aged 18 and Older with Diabetes,* by Age and Sex, 2001
Source (II.3): National Health Interview Survey



Women Aged 18 and Older with Diabetes,* by Race/Ethnicity, 2001**
Source (II.3): National Health Interview Survey



**Reported a health professional has ever told them they have diabetes.*
***Rates reported are crude rates, meaning that they are not adjusted for the different age distributions of these populations.*

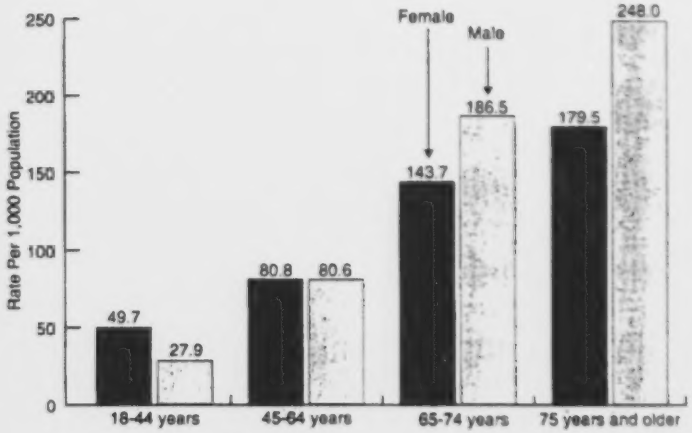
HEART DISEASE

More women die from heart disease than men. In 2001, women under age 45 experienced higher rates of heart disease than men of the same age (49.7 vs. 27.9 per 1,000 population, respectively). However, with increased age, the rates reversed; climbing to 248.0 for men and 179.5 for women aged 75 and older.

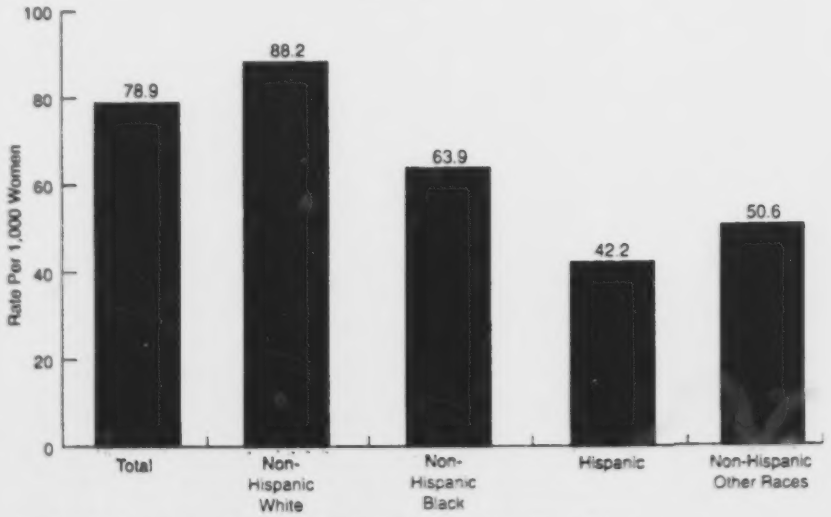
Differences in heart disease among various racial and ethnic groups may be due to the difference in age distributions of these populations. In 2001, non-Hispanic White women exhibited the highest rates of heart disease and were twice as likely as Hispanic women to be diagnosed with the condition.

High blood pressure, obesity, and smoking are significant risk factors for developing heart disease. Health professionals recommend modifying behaviors such as smoking, diet, and exercise to prevent the onset or further progression of the disease.

Adults Aged 18 and Older with Heart Disease,* by Age and Sex, 2001
Source (II.3): National Health Interview Survey



Women Aged 18 and Older with Heart Disease,* by Race/Ethnicity, 2001**
Source (II.3): National Health Interview Survey



*Reported a health professional has ever told them that they have a heart condition or disease.

**Rates reported are crude rates, meaning that they are not adjusted for the different age distributions of these populations.

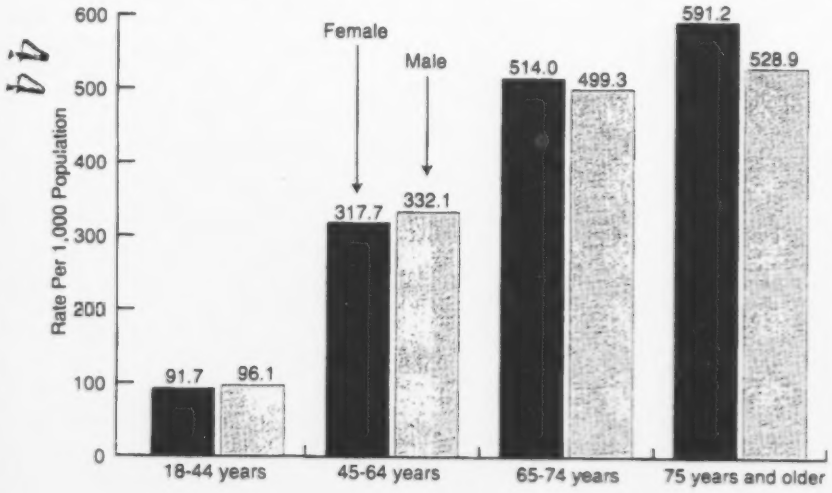
HYPERTENSION

Hypertension (high blood pressure) is a significant risk factor for heart disease and stroke. In 2001, males aged 64 and younger had slightly higher rates of hypertension than their female counterparts. However, rates of hypertension were higher among older women than men. This pattern contrasts with that seen for other major conditions such as heart disease and diabetes, which were higher among younger women than men and lower for women in older age groups.

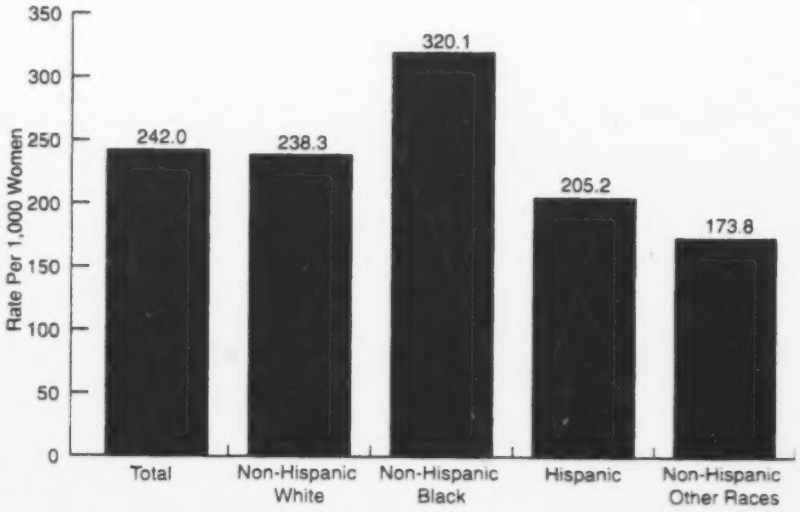
Similar to the trends found in heart disease and diabetes, the rate of hypertension for both women and men increased with age. The rates of hypertension increased from 91.7 among women aged 44 and younger to 591.2 among women aged 75 and older.

Although rates are not adjusted for age, non-Hispanic Black women had higher rates of hypertension than other races and ethnic groups. In 2001, the hypertension rate among non-Hispanic Black women was 1.3 times the rate of non-Hispanic White women and 1.5 times the rate of Hispanic women.

Adults Aged 18 and Older with Hypertension,* by Age and Sex, 2001
Source (II.3): National Health Interview Survey



Women Aged 18 and Older with Hypertension,* by Race/Ethnicity, 2001**
Source (II.3): National Health Interview Survey



*Reported a health professional has ever told them that they have hypertension.

**Rates reported are crude rates, meaning that they are not adjusted for the different age distributions of these populations.

BEST COPY AVAILABLE

INJURY

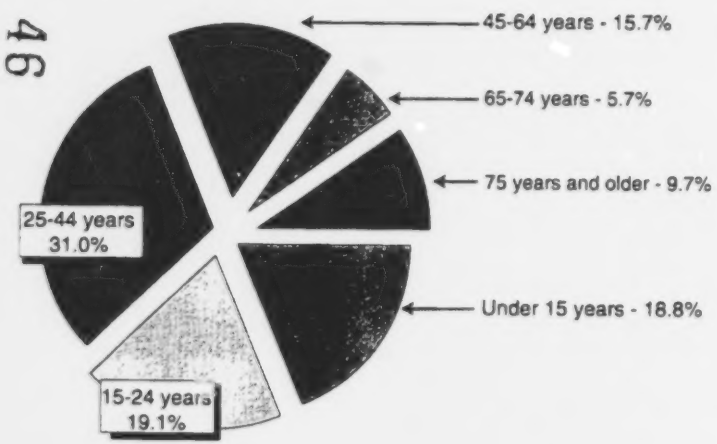
Although many injuries are preventable, in 2000 there were 40.4 million visits to emergency departments (ED) due to injuries, representing a 7.4 percent increase from 1999 (37.6 million). Overall, females accounted for 45 percent of these injury-related ED visits. Among females with injury-related ED visits, the greatest proportion (31.0 percent), were among women aged 25-44.

In 2000, the overall number of injury-related visits to EDs per 100 persons per year was 14.8, with a rate of 13.0 for females and 16.6 for males. For persons aged 44 and younger, males had a higher rate of injury-related ED visits per year than females, with the gender disparity particularly large for persons under 15. However, gender differences were minimal among persons aged 45-74, while females aged 75 and older displayed a higher rate of injury-related ED visits per year than males. Among females, the rate of injuries resulting in an ED visit was highest for women aged 75 and older, with the second highest rate among females aged 15-24.

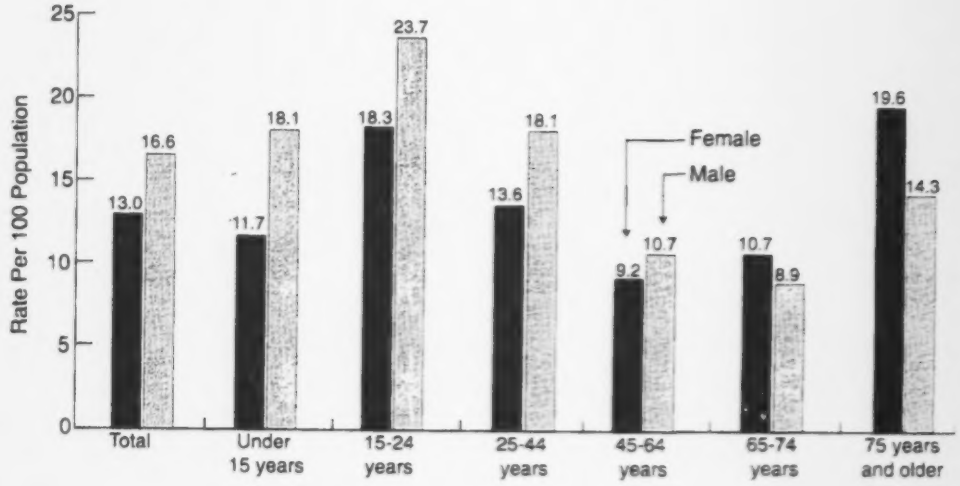
Falls are a leading cause of injury in women, especially among women aged 65 and older. Other injuries commonly resulting in an ED visit result from being struck by or against a person or object, car crashes, overexertion, and cuts.[1]

1Warner M, Barnes PM, and Fingerhut LA. Injury and poisoning episodes and conditions, National Health Interview Survey, 1997. Vital Health Stat 10(202), 2000.

Injury-Related Emergency Department Visits for Females, by Age, 2000
Source (II.10): National Ambulatory Medical Care Survey



Injury-Related Visits to Emergency Departments, by Age and Sex, 2000
Source (II.10): National Ambulatory Medical Care Survey

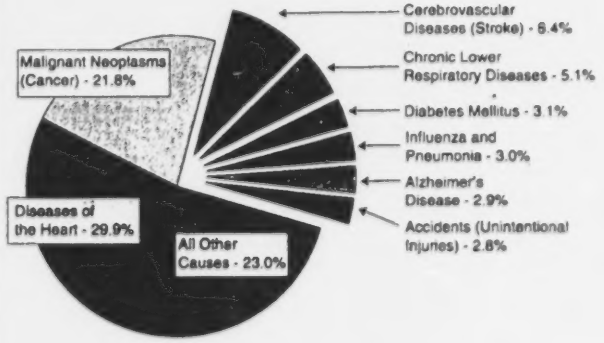


LEADING CAUSES OF DEATH

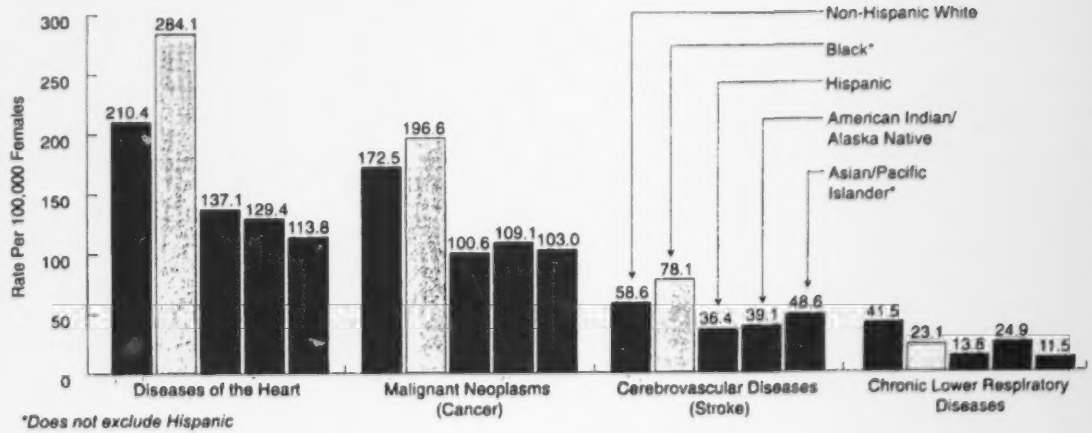
There were 1.2 million deaths among females in 2000. Diseases of the heart and malignant neoplasms (cancer) accounted for more than half of total deaths (365,953 and 267,009 deaths, respectively).

Death rates from the four leading causes of death among females vary by race/ethnicity. In 2000, Black females had the highest death rates for diseases of the heart, malignant neoplasms, and cerebrovascular diseases (284.1, 196.6, and 78.1 per 100,000 females, respectively). Non-Hispanic White females had the highest death rates for chronic lower respiratory diseases (41.5 per 100,000 females). Hispanic females had the lowest rates of death for malignant neoplasms and cerebrovascular disease (100.6 and 48.6 per 100,000 females, respectively), while Asian/Pacific Islander females had the lowest rates of death for diseases of the heart and chronic lower respiratory diseases (113.8 and 11.5 per 100,000 females, respectively).

Leading Causes of Death in Females (All Ages), 2000
Source (II.11): National Vital Statistics System


Cerebrovascular Diseases (Stroke) - 6.4%
Chronic Lower Respiratory Diseases - 5.1%
Diabetes Mellitus - 3.1%
Influenza and Pneumonia - 3.0%
Alzheimer's Disease - 2.9%
Accidents (Unintentional Injuries) - 2.8%
Malignant Neoplasms (Cancer) - 21.8%
Diseases of the Heart - 29.9%
All Other Causes - 23.0%

Age-Adjusted Death Rates from Selected Conditions for Females (All Ages), by Race/Ethnicity, 2000
Source (II.12): National Vital Statistics System



*Does not exclude Hispanic

MENTAL ILLNESS AND SUICIDE

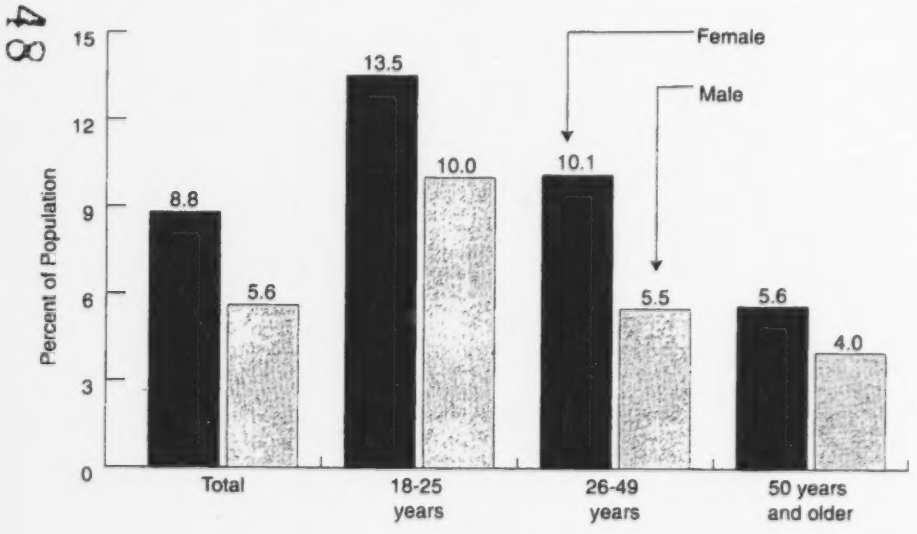
Serious mental illness[1] disproportionately affects women. In 2001, females in all adult age groups were much more likely than males to report serious mental illness in the year prior to the survey. Among those aged 26-49, women were nearly twice as likely as men to have experienced serious mental illness within the past 12 months.

Although the majority of people who suffer from a mental illness do not commit suicide, having a mental illness may increase the likelihood of attempting or committing suicide. People with conditions such as major depression, bipolar disorders, schizophrenia, and personality disorders are at a greater risk for suicide. Furthermore, people who die by suicide are frequently suffering from undiagnosed, undertreated, or untreated depression.[2] In 2000, non-Hispanic White and American Indian/Alaska Native women had especially high rates of suicide at 4.7 and 4.6 suicide deaths per 100,000 females, respectively, as compared to 3.0 for Asian/Pacific Islander, 1.8 for Hispanic, and 1.8 for Black females.

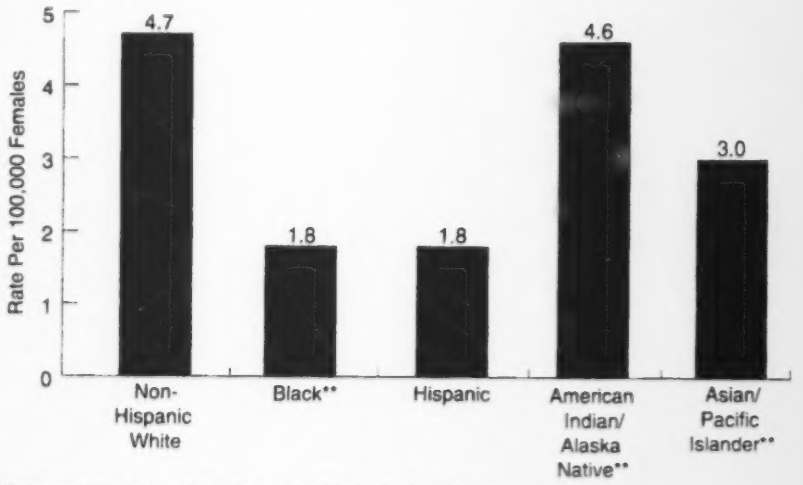
1The National Household Survey on Drug Abuse defines Serious Mental Illness (SMI) as "having a diagnosable mental, behavioral, or emotional disorder that met the DSM-IV criteria and resulted in functional impairment that substantially interfered with or limited one or more major life activities."

2Department of Health and Human Services. National Strategy for Suicide Prevention. A Collaborative Effort of SAMHSA, CDC,

Serious Mental Illness in Past Year, by Age and Sex, 2001
Source (II.4): National Household Survey on Drug Abuse



Suicide Death Rates* for Females Aged 15 Years and Older, by Race/Ethnicity, 2000
Source (II.12): National Vital Statistics System



**Rates are age-adjusted using the year 2000 standard population.*

***Does not exclude Hispanic*

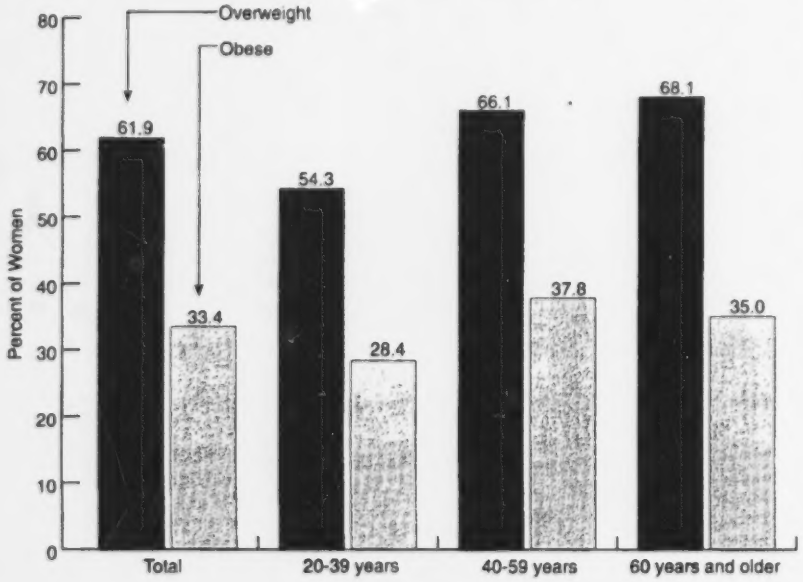
OVERWEIGHT AND OBESITY

Overweight and obesity are linked to chronic conditions such as high blood pressure, heart disease, diabetes, and stroke. An expert panel convened by the National Institutes of Health used height and weight measurements to define overweight as a Body Mass Index (BMI) of 25 kg/m^2 or greater and obesity as a BMI of 30 kg/m^2 or greater. Using these definitions, the 1999-2000 National Health and Nutrition Examination Survey (NHANES) found that 61.9 percent of women were overweight, including the 33.4 percent who were obese. Males were consistently more likely to be overweight than females, while females were more likely to be obese. NHANES found that 61.9 percent of women were overweight, including the 33.4 percent who were obese. Males were consistently more likely to be overweight than females, while females were more likely to be obese. The likelihood of being overweight increased with age, the highest percentage among women aged 40-59 (37.8 percent), followed by women 60 years and older (35.0 percent).

The 1999-2000 NHANES showed the highest prevalence of overweight and obesity in non-Hispanic Black women (77.3 percent overweight, including 49.7 percent obese), followed by Mexican-American women (71.9 percent overweight, including 39.7 percent obese).

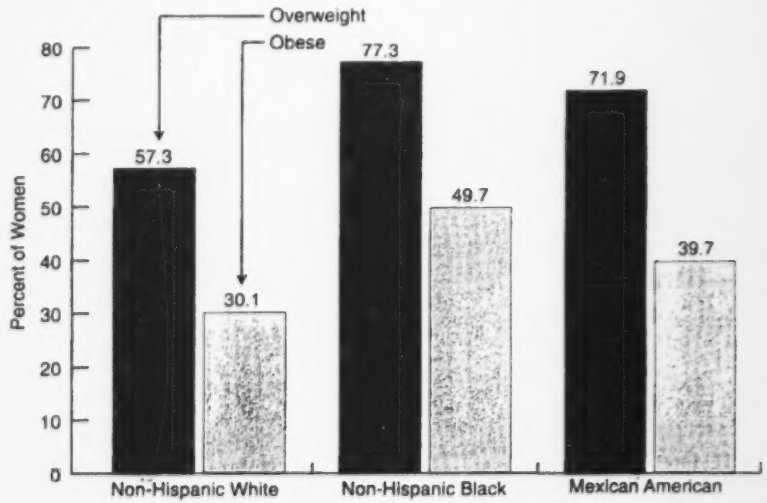
Overweight and Obesity* Among Women Aged 20 and Older, by Age, 1999-2000

Source (II.13): National Health and Nutritional Examination Survey



Overweight and Obesity* in Women Aged 20 and Older, by Race/Ethnicity,1999-2000

Source (II.13): National Health and Nutritional Examination Survey



**Obesity was defined as a body mass index of 30.0 or higher. Overweight was defined as a body mass index of 25.0 or higher, therefore including all those defined as obese.*

SEXUALLY TRANSMITTED DISEASES

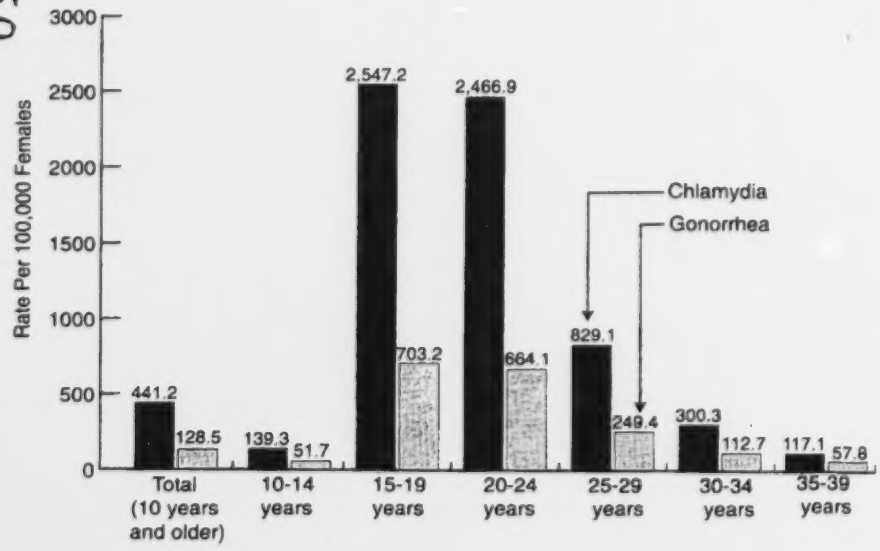
Rates of reportable sexually transmitted diseases (STDs) are particularly high among adolescent females and young adult women. In 2001, chlamydia was the most common infection, followed by gonorrhea, with rates in adolescents aged 15-19 of 2547.2 and 703.2 cases per 100,000 women respectively. The rates for both of these STDs decreased with age.

Rates of chlamydia and gonorrhea were much higher among non-Hispanic Black women than among women of other races and ethnicities, with rates of 1,646.1 and 721.4 per 100,000 women, respectively. American Indian/Alaska Native women had the second highest rates of these diseases.

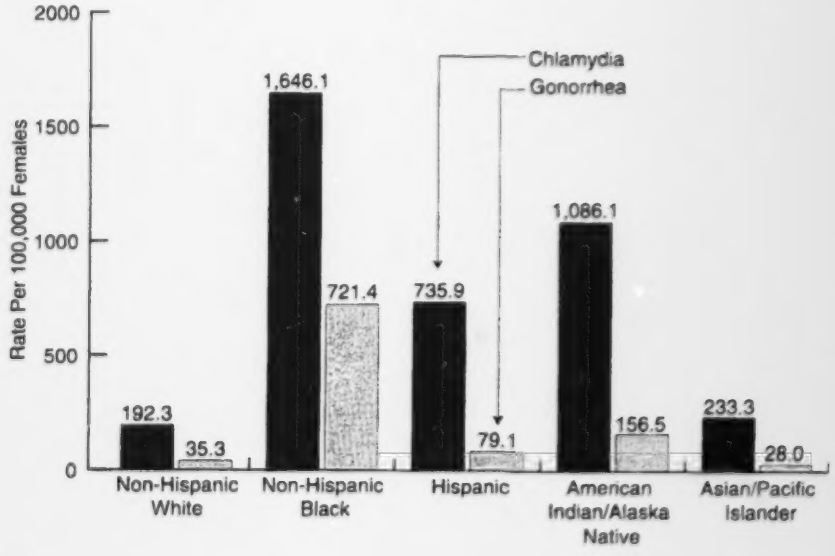
A third reportable STD, syphilis, remained relatively rare among females in 2001 (1.4 per 100,000 women). In 2001, this condition also disproportionately affected non-Hispanic Blacks (8.4 per 100,000 women) and American Indian/Alaska Native women (3.8 per 100,000 women).

Although these conditions are treatable with antibiotics, STDs can have serious health consequences. Active infections can increase the likelihood of contracting HIV, and untreated STDs can lead to pelvic inflammatory disease, infertility, and adverse outcomes of pregnancy.

STDs Among Females, by Age, 2001
Source (II.14): Centers for Disease Control and Prevention



STDs Among Females Aged 10 and Older, by Race/Ethnicity, 2001
Source (II.14): Centers for Disease Control and Prevention



VIOLENCE AND ABUSE

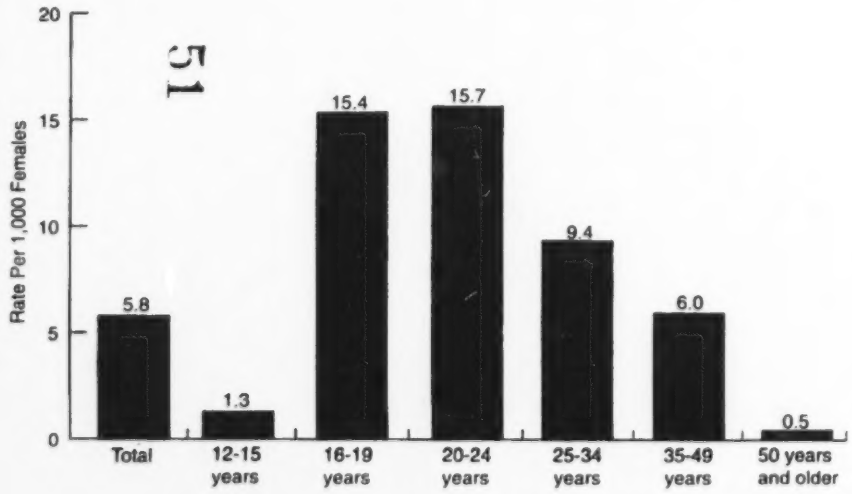
In 1999, there were 3.3 million violent crimes committed against females aged 12 and older. Violent crimes include rape, sexual assault, robbery, and aggravated and simple assault.

Violent crimes are perpetrated by strangers, friends, acquaintances, other relatives, or intimate partners. However, women are more likely to be the victims of violent acts committed by intimate partners. In 1999, there were 791,210 violent crimes committed by intimate partners, 84.8 percent of which were committed against women. Women were also more likely to be victims of homicide by intimate partners than were men. The overall rate of intimate partner violence against women was 5.8 per 1,000 in 1999, but rates were higher among women aged 16-19 and 20-24 (15.4 and 15.7 per 1,000, respectively). Age patterns for intimate partner violence were similar among various racial and ethnic groups, peaking between the ages of 20-24 years.

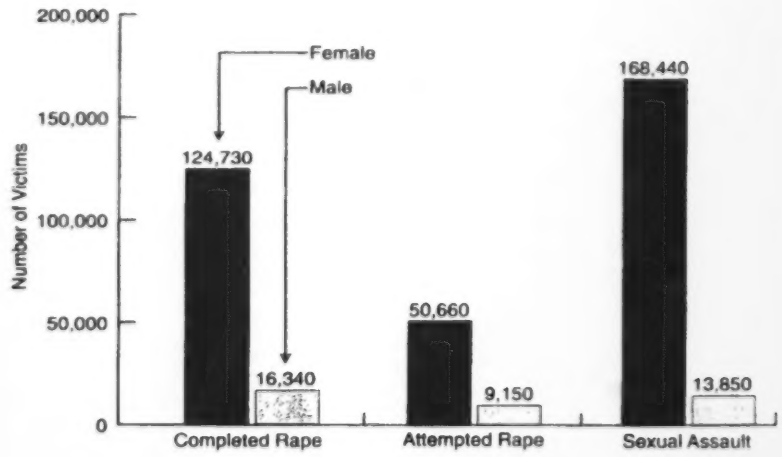
The majority of sexual assaults and rapes also occur among women. In 1999, there were 343,830 sexual assaults and attempted and completed rapes reported, of which 87.3 percent were reported by women. Thirty-eight percent of female survivors of completed rape also sustained additional injuries, while 39 percent of attempted rape survivors and 17 percent of sexual assault survivors reported additional injuries. Reported non-fatal injuries ranged from bruises and chipped teeth to broken bones and gunshot wounds.[1]

1Rennison CM. Rape and Sexual Assault: Reporting to Police and Medical Attention, 1992-2000. U.S. Department of Justice, Bureau of Justice Statistics Special Report, August 2002.

Crimes of Violence Against Females by Intimate Partners, 1999
Source (II.15): National Crime Victimization Survey



Rape and Sexual Assault Victims Aged 12 and Older, by Sex, 1999
Source (II.16): National Crime Victimization Survey



PRENATAL CARE

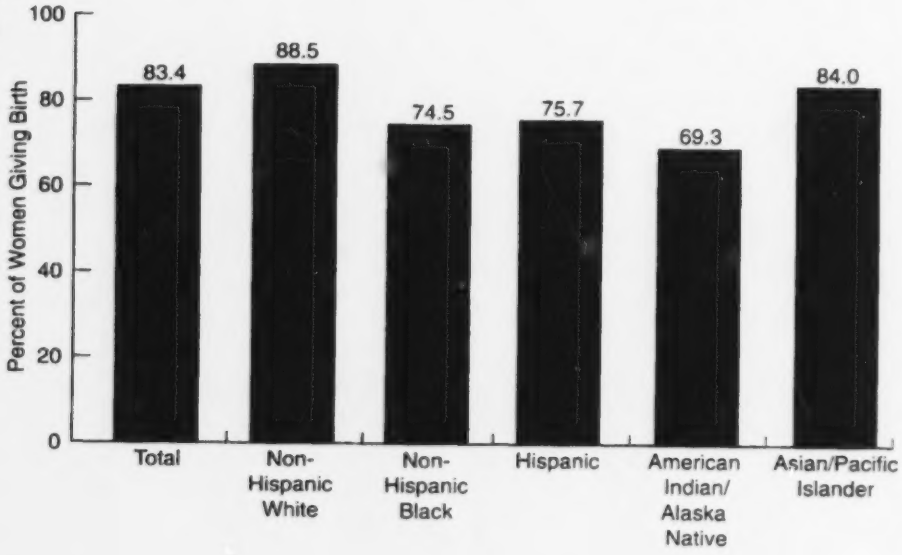
There were 4,025,933 births in the U.S. in 2001. Of the women giving birth, 83.4 percent began prenatal care in the first trimester of pregnancy, increasing slightly from the 2000 rate. This figure has risen 10 percent since 1989, when 75.5 percent of women received early prenatal care.

Racial and ethnic variations exist in receiving early prenatal care. In 2001, 88.5 percent of non-Hispanic White women and 84.0 percent of Asian/Pacific Islander women received early prenatal care compared to 74.5 percent of non-Hispanic Black, 75.7 percent of Hispanic, and 69.3 percent of American Indian/Alaska Native women. The proportion of non-Hispanic Black, Hispanic, and American Indian/Alaska Native women receiving early prenatal care increased by 20-26 percent between 1990 and 2001.

The percentage of women beginning prenatal care in the third trimester or going without prenatal care dropped from 6.4 percent in 1989 to 3.7 percent in 2001. However, non-Hispanic Black, Hispanic and American Indian/Alaska Native women were 2.7 to 3.7 times more likely to begin care late or to receive no prenatal care than non-Hispanic White women in 2001. Overall, almost 42,000 women received no prenatal care.

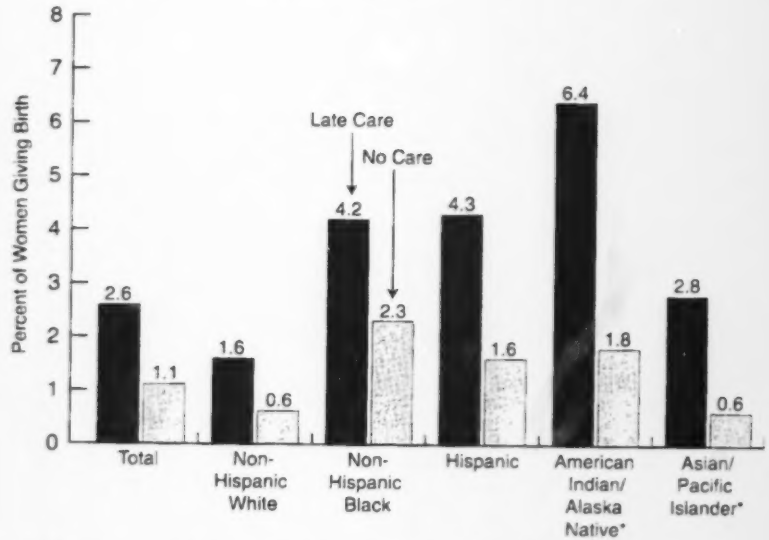
Mothers Beginning Prenatal Care in the First Trimester (All Births), by Race/Ethnicity, 2001

Source (II.17): National Vital Statistics System



Mothers Receiving Late or No Prenatal Care (All Births), by Race/Ethnicity, 2001

Source (II.17): National Vital Statistics System



*National Vital Statistics System, Final Natality Data, 2001, Unpublished data

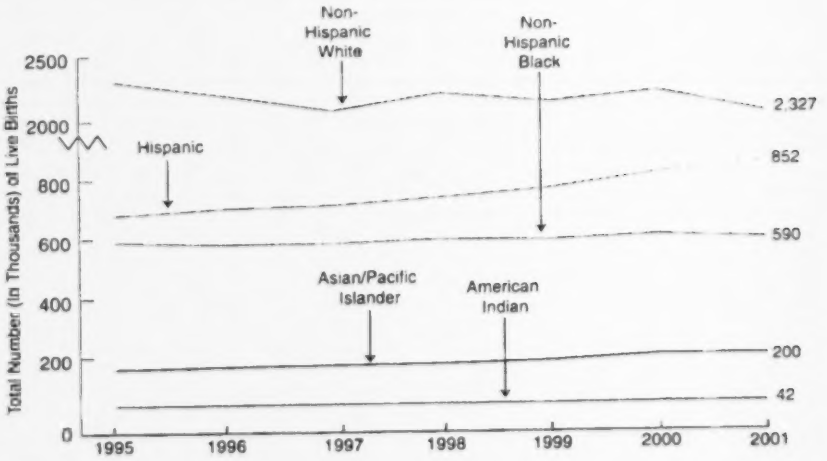
LIVE BIRTHS

From 1995 to 2001 the total number of live births increased 4.1 percent from 3.8 million to 4.0 million. Although non-Hispanic White women had the greatest number of births during these years, the total number of live births among this population decreased 2.4 percent. The number of live births in other racial and ethnic groups increased during this period, with Hispanics and Asian/Pacific Islander women experiencing the largest growth rates; 20.2 and 20.0 percent respectively.

The total birth rate in the U.S. in 2001 was 14.5 births per 1,000 population, a slight decrease (1.4 percent) from the rate reported in 2000. Younger women had higher birth rates than older women. Birth rates among Asian/Pacific Islander and non-Hispanic White women were the highest in women aged 25-29, while other racial and ethnic groups had their highest rates in the 20-24 years age group. Overall, Hispanic women aged 20-24 had the highest birth rate (186.0 per 1,000 women). Among women aged 30 and older, Asian/Pacific Islander women had the highest birth rates.

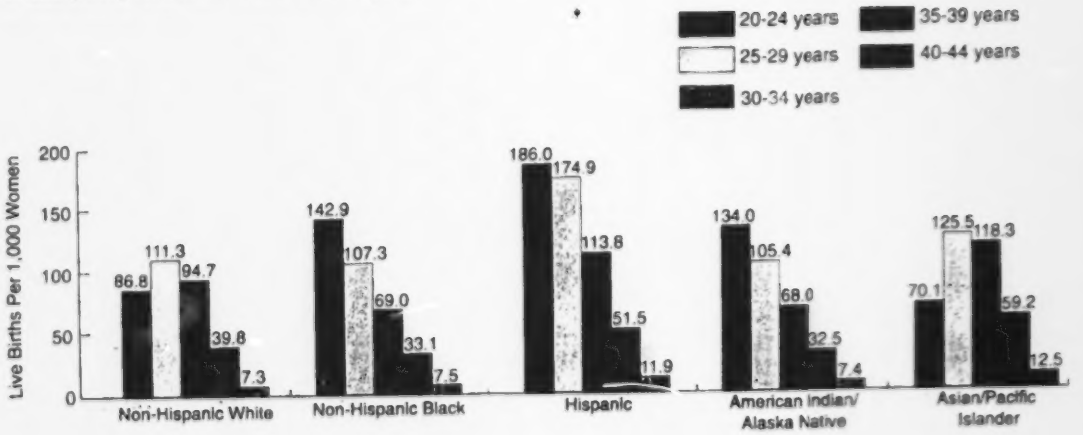
Live Births, by Race/Ethnicity, 1995-2001

Source (II.17): National Vital Statistics System

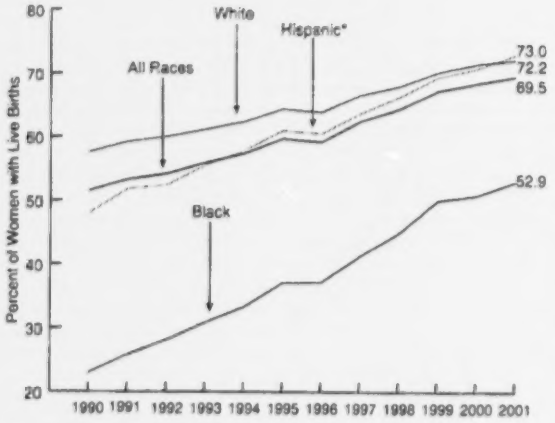


Birth Rates, by Age and Race/Ethnicity of Mother, 2001

Source (II.17): National Vital Statistics System

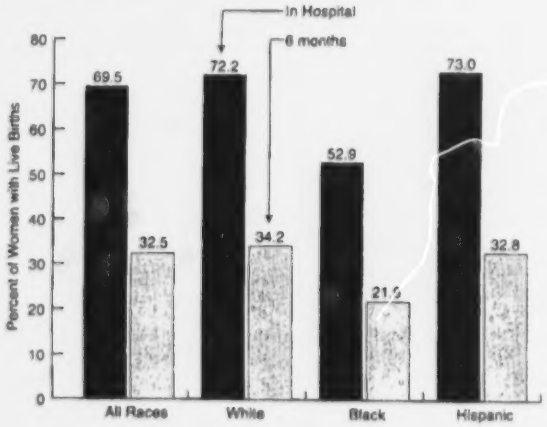


In-Hospital Breastfeeding, by Race/Ethnicity, 1990-2001
Source (II.18): Abbott Laboratories



*May be of any race

Women Breastfeeding in Hospital and at 6 Months Postpartum, by Race/Ethnicity, 2001
Source (II.18): Abbott Laboratories



BREASTFEEDING

Breastfeeding has numerous benefits for women and their infants.[1] Through the 1970s and early 1980s, the percentage of mothers who began breastfeeding in the hospital increased steadily to 61.9 percent, but then gradually declined to 51.5 percent by 1990. Between 1990 and 2001, the breastfeeding initiation rates steadily increased among Black, Hispanic, and White women.

In 2001, breastfeeding rates in the hospital were 72.2 percent among Whites, 73.0 percent among Hispanics, and 52.9 percent among Blacks. These rates were the highest recorded since national breastfeeding data have been collected. However, disparities remain between Black women and women of other racial and ethnic groups.

The percentage of women who report that they are still breastfeeding at 6 months postpartum reached a high of 32.5 percent in 2001. At 6 months postpartum, 34.2 percent, 32.8 percent, and 21.9 percent of White, Hispanic, and Black women, respectively, were still breastfeeding.

Breastfeeding rates were highest among women who were aged 25 years and older, White or Hispanic, college educated, not participating in the Supplemental Nutrition Program for Women, Infants, and Children (WIC), and/or living in the western States. Women were also more likely to initiate breastfeeding with their first child, but women with more than one child were slightly more likely to continue breastfeeding at 6 months postpartum. While maternal employment has little impact on breastfeeding initiation, women who are employed full-time are less likely to breastfeed 6 months after the birth of their child than women who are not employed or working part-time.[2]

1U.S. Department of Health and Human Services. HHS Blueprint for Action on Breastfeeding, Washington, DC: U.S. Department of Health and Human Services, Office on Women's Health, 2000. http://www.4woman.gov/Breastfeeding/bluprntbk2.pdf

2Ryan AS, Wenjun Z, Acosta A. Breastfeeding continues to increase into the new millennium. Pediatrics 2002; 110 (6): 1103-1109.

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MATERNAL MORBIDITY

Morbidity associated with pregnancy can lead to serious physical and mental health problems. The three most frequently reported medical risk factors for women having live births in 2001 were pregnancy-associated hypertension (37.7 per 1,000 live births), diabetes (31.1 per 1,000 live births), and anemia (25.0 per 1,000 live births). Anemia occurs more frequently among women aged 20 years or younger while women aged 40 years or older are at greater risk for chronic conditions such as diabetes (9.2 per 1,000 live births vs. 71.7) and cardiac disease (2.7 per 1,000 live births vs. 9.5).

Maternal illness and pregnancy-complications during labor and delivery include conditions such as diabetes, hypertensive disorders, cardiovascular disease, hemorrhage, amniotic cavity infections, and obstetric trauma. In 1999, 31.4 percent of women discharged from hospitals experienced these conditions, although complications occurred more frequently in women who were at the ends of the age spectrum. Females aged 15 years and younger, who delivered one or more infants had the highest percentage of deliveries with complications (49.4 percent). While data are not available for other races/ethnicities, rates of complications during pregnancy varied between Black and White women (35.4 per 100 deliveries vs. 30.5, respectively) in 1999.

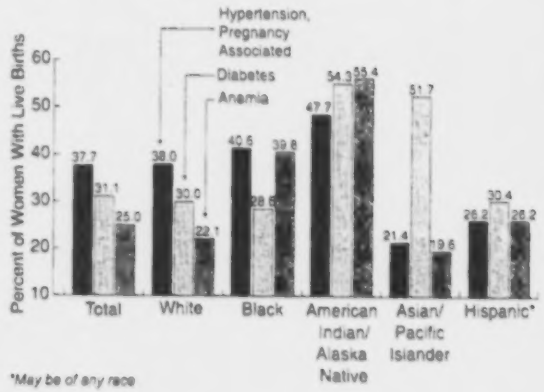
Excessive weight gains in pregnancy have prompted attention to the relationship of gestational weight gain and subsequent obesity in women. In 2001, 18.5 percent of women having a single live birth gained more than 40 pounds, the uppermost weight gain limit recommended for any Body Mass Index[1] category; this percentage increased to 19.1 for all women having live births.

During the past decade, the proportion of live births to women aged 35 years or older has steadily increased. In 2001, 13.6 percent of all live births occurred to women aged 35 years or older, an increase of 8 percent since 1997. Women in this age group were more likely to experience such conditions as diabetes, cardiac disease, and chronic hypertension than women under 35 years of age.

1Body Mass Index (BMI) is a measure of weight in relation to height.

Medical Risk Factors During Pregnancy per 1,000 Live Births, by Race/Ethnicity, 2001

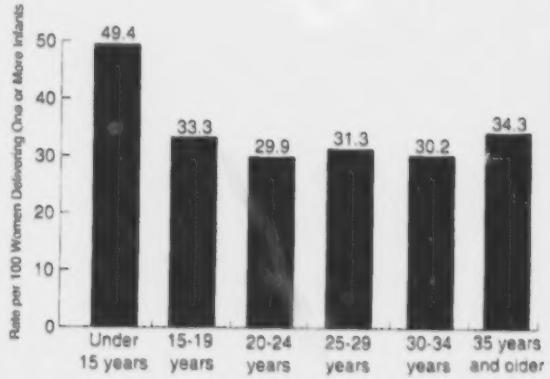
Source (II.17): National Vital Statistics System



*May be of any race

Maternal Illness and Pregnancy-Complications during Hospitalized Labor and Delivery, by Age, 1999

Source (II.19): National Hospital Discharge Survey



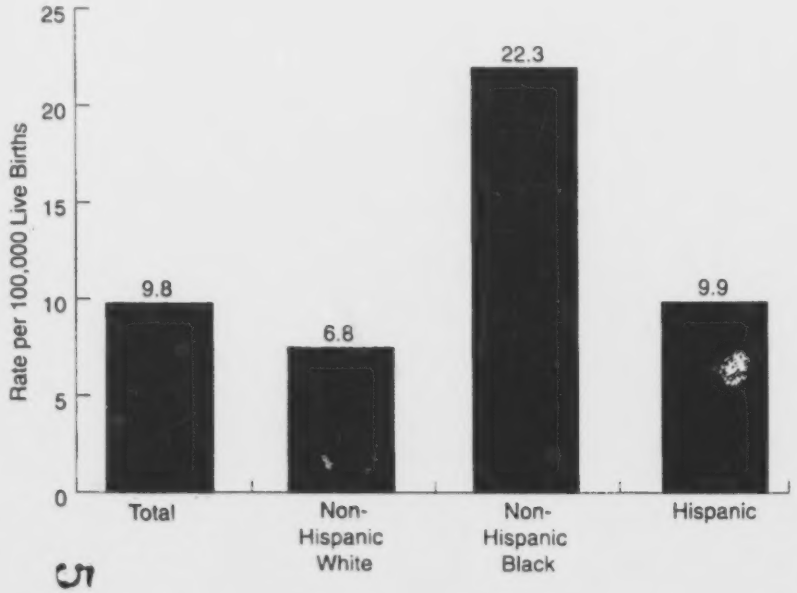
MATERNAL MORTALITY

Between 1970 and 1980, maternal mortality in the U.S. decreased from 21.5 to 9.4 deaths per 100,000 live births, a 56 percent drop. However, from 1980-1998, the rate remained between 6 and 7 maternal deaths per 100,000 live births. In 2000, there were 396 maternal deaths related to complications of pregnancy, childbirth, and the postpartum period, a rate of 9.8 per 100,000 live births. While the number of maternal deaths can vary from year to year, the change in the number of maternal deaths since 1998 also reflects new classification and coding of maternal deaths starting with 1999 data.

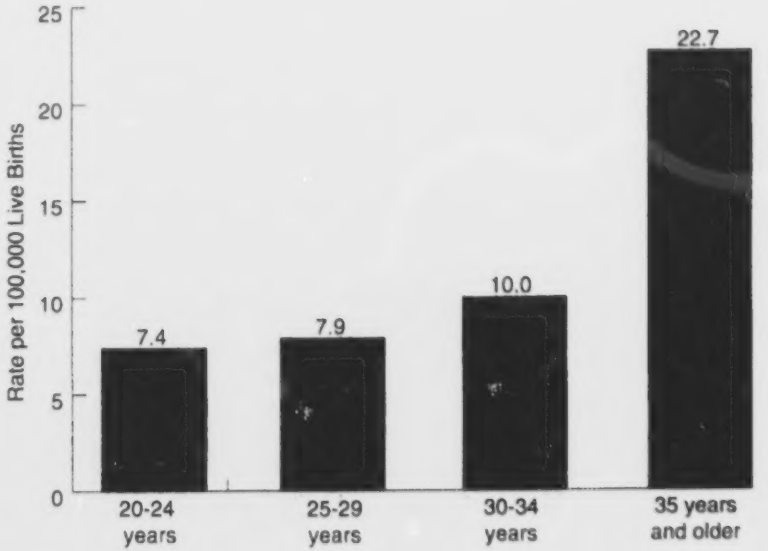
In 2000, the maternal mortality rate for non-Hispanic Black women (22.3 per 100,000 live births) was greater than three times the rate for non-Hispanic White women (6.8 per 100,000 live births) and more than twice the rate for Hispanic women (9.9 per 100,000 live births).

The risk of maternal death increases with age. In 2000, women aged 35 and older had nearly three times the risk of death as women aged 25-29 (22.7 and 7.9 per 100,000 live births, respectively). Black women aged 35 and older had the highest rate of maternal mortality of approximately 63 deaths per 100,000 live births.

Maternal Mortality, by Race/Ethnicity, 2000
Source (II.12): National Vital Statistics System



Maternal Mortality, by Age, 2000
Source (II.20): National Vital Statistics System



HEALTH RESOURCES AND SERVICES ADMINISTATION'S POPULATIONS AND PROGRAMS

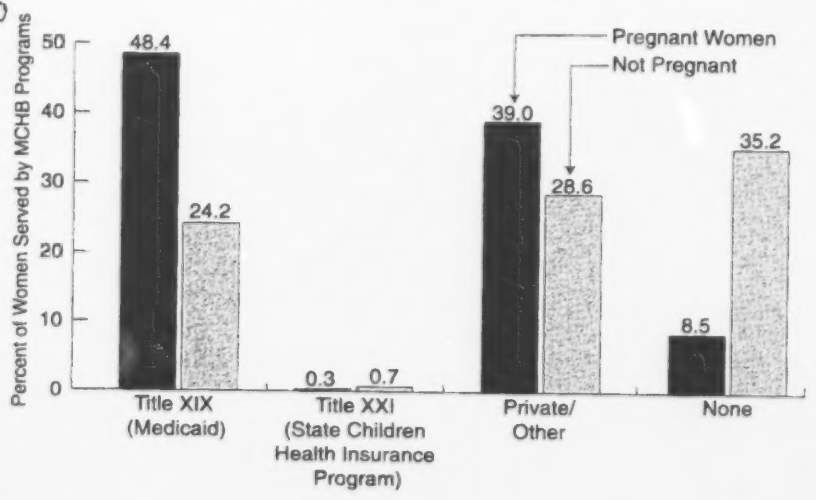
The Health Resources and Services Administration (HRSA) serves women of all ages, racial and ethnic backgrounds, and various socioeconomic groups including, uninsured and underserved women; rural, migrant, and immigrant women; homeless women; women living with HIV/AIDS; and pregnant women.

In 2001, 59.3 percent of the 10 million clients served by HRSA-supported health centers were female. During this year, 4,480,591 women were served through Title V-supported Maternal and Child Health Block Grant programs. Among HRSA clients, 48.4 percent of pregnant women reported their primary source of insurance coverage as Medicaid. Among women who were not pregnant, 35.2 percent had no source of health insurance coverage.

Among the women served by these community and migrant health centers, 84.8 percent received a Pap smear within the past 3 years; a higher rate than the national average. Women aged 50 and older served in HRSA-supported health centers also had higher rates of receiving a mammogram than women in the general population.

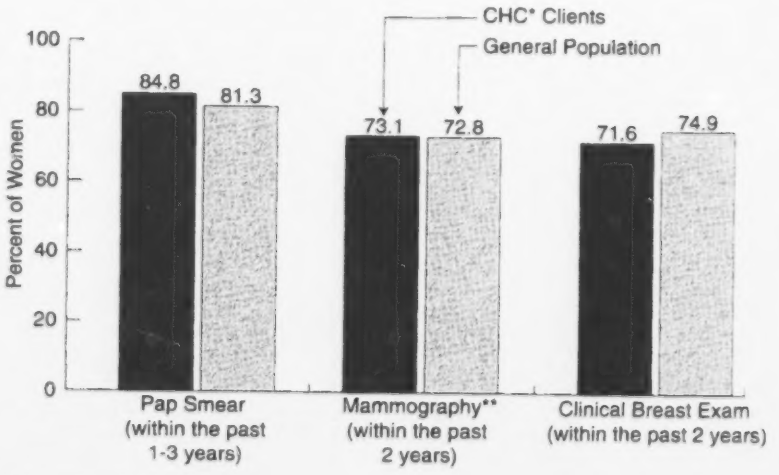
Primary Source of Health Insurance Coverage Among Women Served by Maternal and Child Health Programs, 2001

Source (II.21): Bureau of Primary Health Care



Receipt of Recommended Clinical Preventive Services by Women Served by Federally Qualified Health Centers, 2001

Source (II.22): Bureau of Primary Health Care



*Community Health Center

**Women aged 50 and older

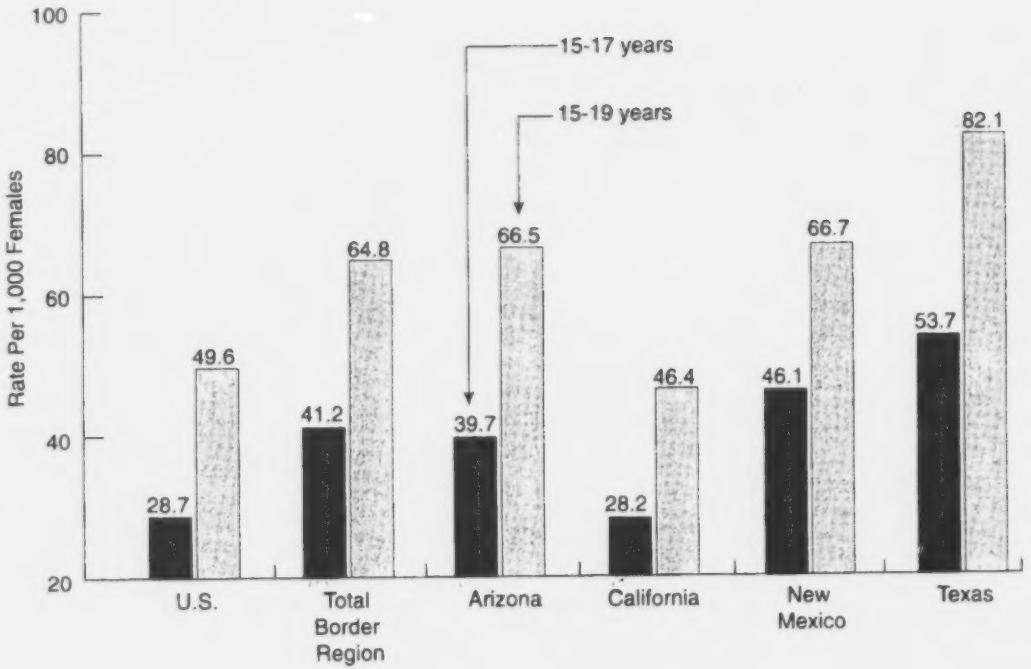
BORDER HEALTH

Health care challenges are prevalent among persons living along the 2,000 mile-long U.S.-Mexico border region, stretching from San Ysidro, California, to Brownsville, Texas, and extending 62 miles north and south of the border. The U.S. side of the border area consists of 48 counties in four States. More than a third of U.S. border families live at or below the poverty line. The Health Resources and Services Administration (HRSA) addresses border health issues through investments in primary health care, maternal and child health services, HIV/AIDS prevention and treatment, and programs to train and place health professionals where needed most. HRSA has created a Division of Border Health to work with the U.S.-Mexico Border Health Commission, the Secretaria de Salud, Mexico, and the Pan American Health Organization Field Office.

A health issue of particular concern in the border region is the high rate of teen births. In 1999, females aged 15-19 in the border region had 64.8 births per 1,000 females of this age group, as compared to a rate of 49.6 nationally. In the Texas border region, the rate of births among females aged 15-19 was 82.1 per 1,000 females of this age. HRSA's prenatal care and promotora outreach programs foster the use of early prenatal care, father involvement, and proper nutrition.

Live Births by Females Aged 15-19, by Border Area,* 1999

Source (II.23): Health Resources and Services Administration



*Border area includes counties within 100 km. of U.S.-Mexico border, including 4 counties in Arizona, 2 counties in California, 6 counties in New Mexico, 32 counties in Texas.

IMMIGRANT WOMEN

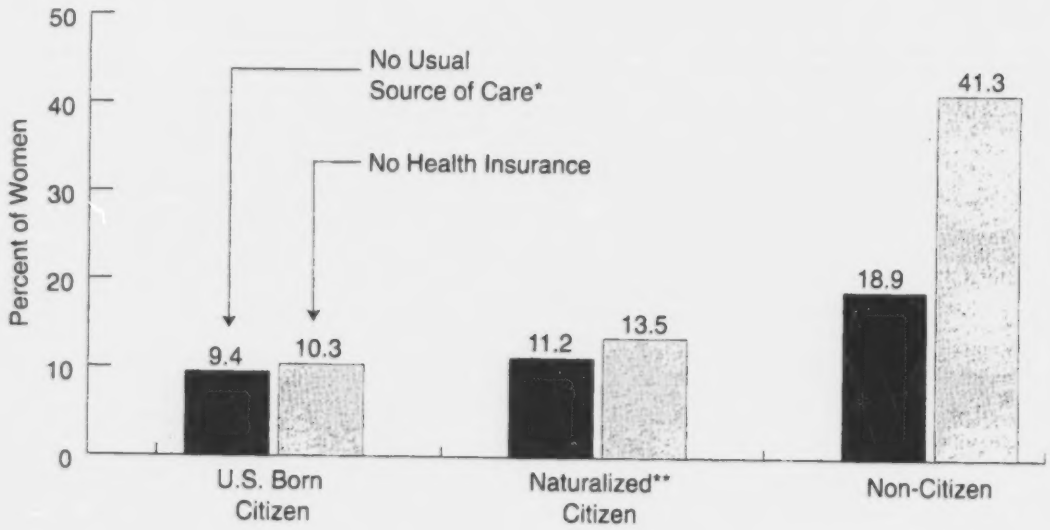
Immigrant populations, especially non-citizens, face challenges in accessing health care services, including language and cultural barriers. In the year 2000, there were an estimated 12.8 million women aged 18 and older residing in the U.S. who were born in other countries, 58.0 percent of whom were non-citizens.[1]

In 2001, women who were non-citizens were more likely than naturalized citizens and U.S.-born women to lack a usual source of care (18.9 percent as compared to 11.2 and 9.4 percent of naturalized and U.S.-born citizens, respectively). Non-citizens were also more likely to report having no health insurance than U.S.-born citizens (41.3 compared to 10.3 percent).

1 U.S. Census Bureau. Current Population Survey - March 2000 Detailed Tables (PPL-135) http://www.census.gov/population/www/socdemo/foreign/p20-534.html

Women Aged 18 and Older Lacking a Usual Source of Care and Health Insurance, by Citizenship Status, 2001

Source (II.3): National Health Interview Survey



**Defined as not having a place they usually go to when they are sick.*

***Person not born in the U.S., but holds U.S. citizenship.*

INCARCERATED WOMEN

In the past decade, the number of incarcerated women has increased dramatically. Although the rate of incarceration for women remains much lower than it is for men, from 1990 to 2000, the total number of women in Federal and State prisons and local jails nearly doubled (83,253 to 165,649).

Substance abuse is a major health concern for incarcerated females. In 1997, 40.4 percent of females were using drugs, and 29.1 percent were under the influence of alcohol, at the time of their offense. Additionally, 62.4 percent reported using drugs sometime during the month prior to their offense. Obtaining help to address these behaviors is important. In 1997, 19.6 percent of incarcerated females received treatment for substance abuse, and 31.9 percent had participated in another type of substance abuse program, since admission.

A history of victimization is another health concern for many women under correctional authority. In 1997, 44 percent of females on probation or incarcerated in local jails and State prisons reported having been physically or sexually assaulted at some point in their lives, with over two-thirds reporting an assault before the age of 18 years. Incarcerated females also have an increased risk for infectious diseases, mental illness, chronic disease, and reproductive health problems. In 1997, an estimated 2,200 females in State prisons (3.5 percent) tested HIV-positive, and 23 percent received medication for an emotional disorder.[1]

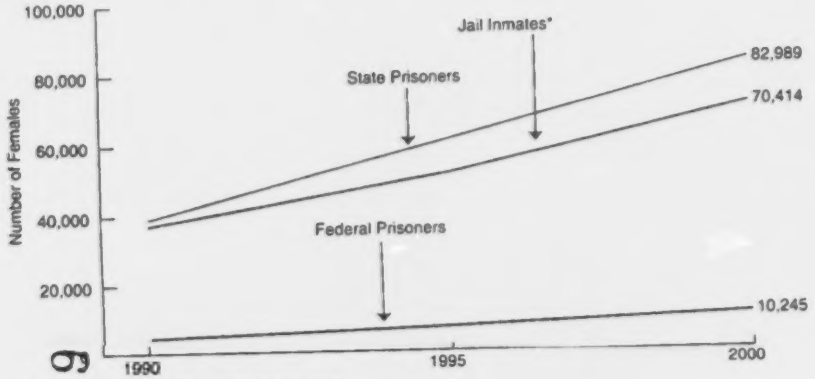
The health and well being of incarcerated women may also affect their children. In 1997, 65.3 percent of women in State custody and 58.8 percent of women in Federal custody had minor children, and 5 percent were pregnant at the time of admission.[2]

1Greenfeld LA and Snell TL. Women Offenders. U.S. Department of Justice, Bureau of Justice Statistics Special Report, December 1999. http://www.ojp.gov/bjs/pub/pdf/wo.pdf

2Mumola CJ. Incarcerated Parents and Their Children. U.S. Department of Justice, Bureau of Justice Statistics Special Report, August 2000. http://www.ojp.gov/bjs/pub/pdf/iptc.pdf

Female Federal and State Prisoners and Local Jail Inmates, 1990, 1995, and 2000

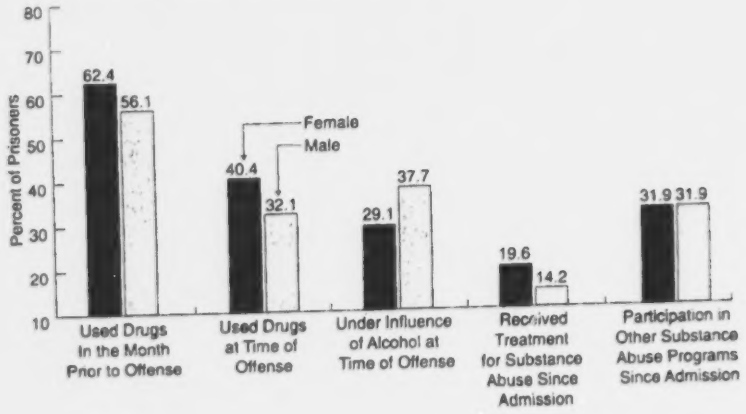
Source (11.24): U.S. Department of Justice



*Includes juveniles and is based on 1-day counts.

State Prisoner Drug and Alcohol Use and Substance Abuse Treatment, by Sex, 1997

Source (11.25): National Archive of Criminal Justice Data



RURAL AND URBAN HEALTH

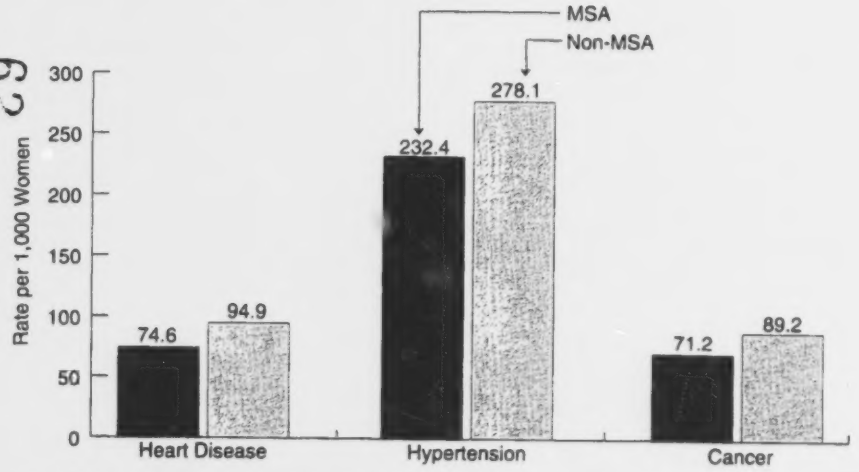
In 2000, 59 million people, or approximately 21 percent of the population, lived in a rural area.[1] A variety of factors, including an older population, a limited supply of health care providers, and further distances from health care resources may contribute to special health concerns among non-metropolitan populations. In 2001, women living in non-metropolitan areas were more likely to have ever been told by a health care provider that they have heart disease, hypertension, and cancer than women in metropolitan areas.

Health behaviors such as physical activity, smoking, and drinking may contribute to poorer overall health status. Although women living in metropolitan areas were slightly more likely to report being heavy drinkers, a higher percentage of women living in non-metropolitan areas were current smokers and did not engage in regular physical activity as compared to women living in metropolitan areas.

1 U.S. Census Bureau 2000. Census 2000 Summary File 1. Table P2. http://factfinder.census.gov/servlet/BasicFactsServlet

Health Conditions* in Women Aged 18 and Older, by Metropolitan Statistical Area (MSA) Status, 2001**

Source (II.3): National Health Interview Survey

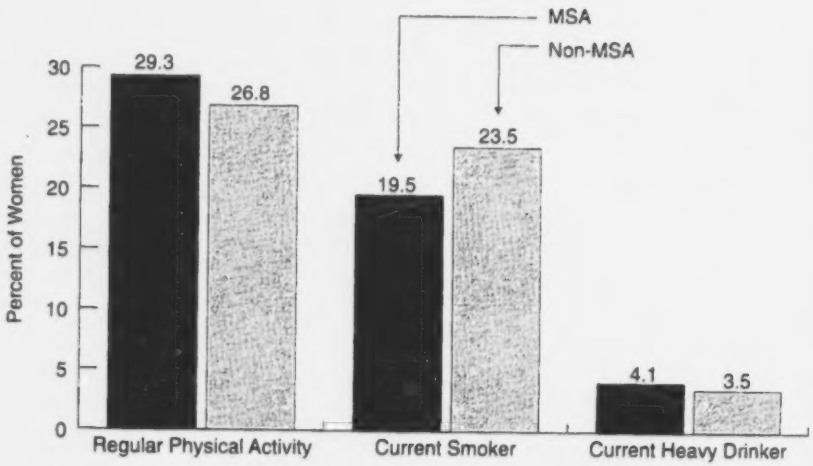


*Have ever been told by a health care provider they did have this condition.

**Metropolitan Statistical Areas (MSA) include at least: one city with 50,000 or more inhabitants,or a Census Bureau-defined urbanized area (of at least 50,000 inhabitants) and a total metropolitan population of at least 100,000 (75,000 in New England). Additional "outlying counties" are included in the MSA if they meet specified requirements of commuting to the central counties and other selected requirements of metropolitan character. In New England, the MSAs are defined in terms of cities and towns rather than counties.

Health Behaviors Among Women Aged 18 and Older, by Metropolitan Statistical Area (MSA) Status, 2001**

Source (II.3): National Health Interview Survey



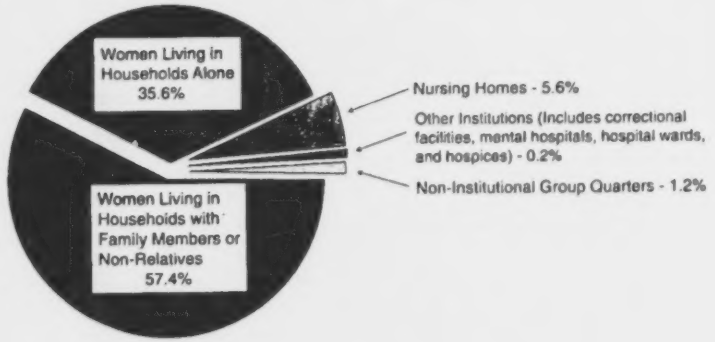
OLDER WOMEN

From 1980 to 2000, the remaining life expectancy for a woman aged 65 increased from 18.3 to 19.2 years. As life expectancy has lengthened, so has the proportion of the population comprised of older women. In 2001, there were 19.1 million women aged 65 and older, representing 13.6 percent of the female population. These women outnumbered men by larger proportions as ages increased, comprising 54.8 percent of people aged 65 to 74 and 67.9 percent of people aged 85 and over.

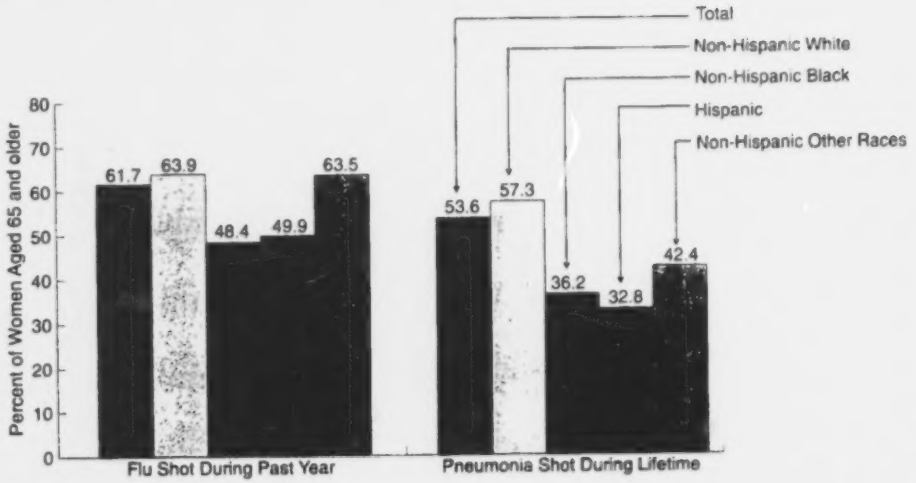
Although the frequency of certain health problems and the need for care increases among women as they age, in 2000 more than 35 percent of women aged 65 and older lived in a household alone, while 57.4 percent lived with other family members or non-relatives. Only 5.6 percent of women aged 65 and older resided in a nursing home in 2000.

The Centers for Disease Control and Prevention also recommends that adults aged 65 and older have an annual influenza (flu) vaccination as well as a pneumococcal vaccination at least once. In 2001, 61.7 percent of women over 65 reported having a flu shot in the past year and 53.6 percent reported they have ever had a pneumonia shot. The rates of women receiving these vaccinations were highest among non-Hispanic White women, while non-Hispanic Black women and Hispanic women reported the lowest rates.

Living Situations of Women Aged 65 and Older, 2000
Source (II.26): U.S. Census Bureau

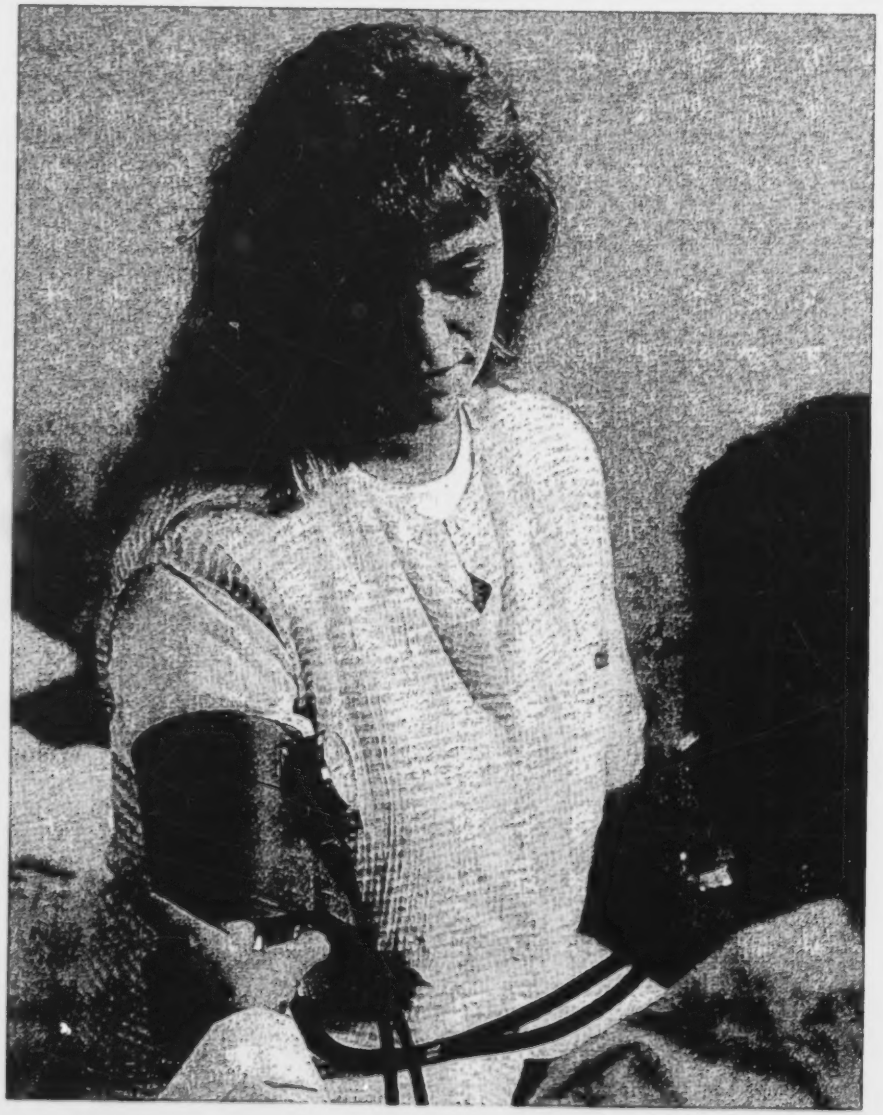

Women Living in Households Alone 35.6%
Women Living in Households with Family Members or Non-Relatives 57.4%
Nursing Homes - 5.6%
Other Institutions (Includes correctional facilities, mental hospitals, hospital wards, and hospices) - 0.2%
Non-Institutional Group Quarters - 1.2%

Self-Report of Receipt of Vaccinations by Women Aged 65 and Older, by Race/Ethnicity, 2001
Source (II.3): National Health Interview Survey



HEALTH SERVICES UTILIZATION

Availability and access to quality health services directly affects the health of women. For women with disabilities, poor health status, poverty, or lack of insurance, access to a range of health services, preventive treatments, and rehabilitation is critical to preventing disease and promoting quality of life. The following section presents data on women's health services utilization, including indicators on insurance, usual source of care, health care financing and expenditures, and use of preventive, dental, hospital, mental health, and home health and hospice services.



USUAL SOURCE OF CARE

A usual source of care has been positively associated with receipt of preventive care,[1,2] access to care,[3] continuity of care, decreased hospitalization, and lower health care costs.[4] Although 90.8 percent of women reported having a place they usually go to when they are sick or need advice on health in 2001, this was lowest among women aged 18-24 (82.0 percent). The proportion of women with a usual source of care increased with age, with nearly all (96.7 percent) women aged 65 and older having a usual source of care.

Though most women across racial and ethnic groups had an office-based usual source of care, non-Hispanic White women were more likely to have office-based care than women in other racial/ethnic groups in 2000. Non-Hispanic Black women were more likely to use a hospital outpatient department or emergency room for their usual source of care than other groups. Hispanic women were most likely to lack a usual source of care (20.8 percent) and, non-Hispanic White women were most likely to have a usual source of care (92.6 percent).

1Ettner SL: The relationship between continuity of care and the health behaviors of patients: Does a usual physician make a difference? Medical Care 37(6): 547-55, 1999.

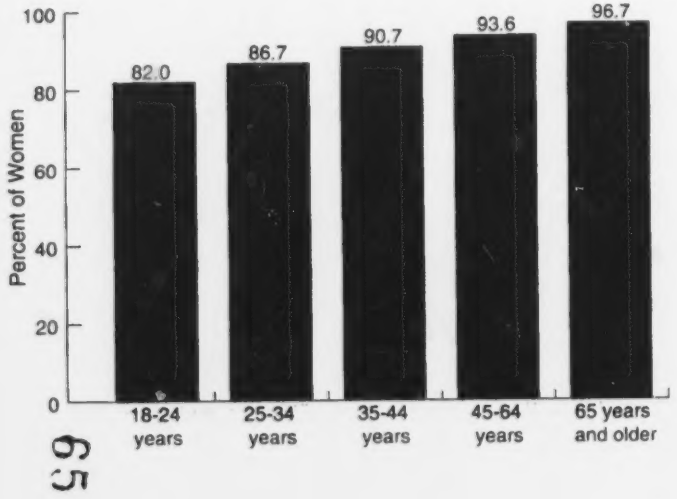
2Ettner SL: The timing an preventive services for women and children: The effect of having a usual source of care. American Journal of Public Health 86(12):1748-54, 1996.

3Sox CM, Swartz K, Burstin HR, Brennan TA: Insurance or a regular physician: Which is the most powerful predictor of health care? American Journal of Public Health 88(3):364-70, 1998.

4Weiss LJ, Blustein J: Faithful patients: The effect of long-term physician-patient relationships on the cost and use of health care by older Americans. American Journal of Public Health 86(12):1747-7,

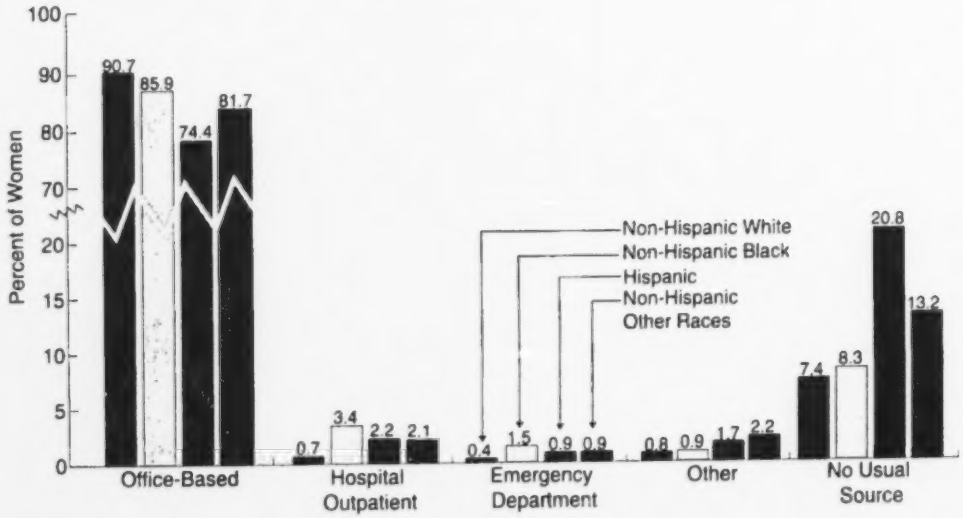
Women Aged 18 and Older with a Usual Source of Care, by Age, 2001

Source (III.1): National Health Interview Survey



Usual Source of Care For Women Aged 18 and Older, by Race/Ethnicity, 2001

Source (III.1): National Health Interview Survey



HEALTH INSURANCE

People with health insurance are more likely to have a usual source of medical care and to use preventive care, while people without health insurance are more likely to have unmet medical needs and to use hospital emergency rooms for routine care.[1]

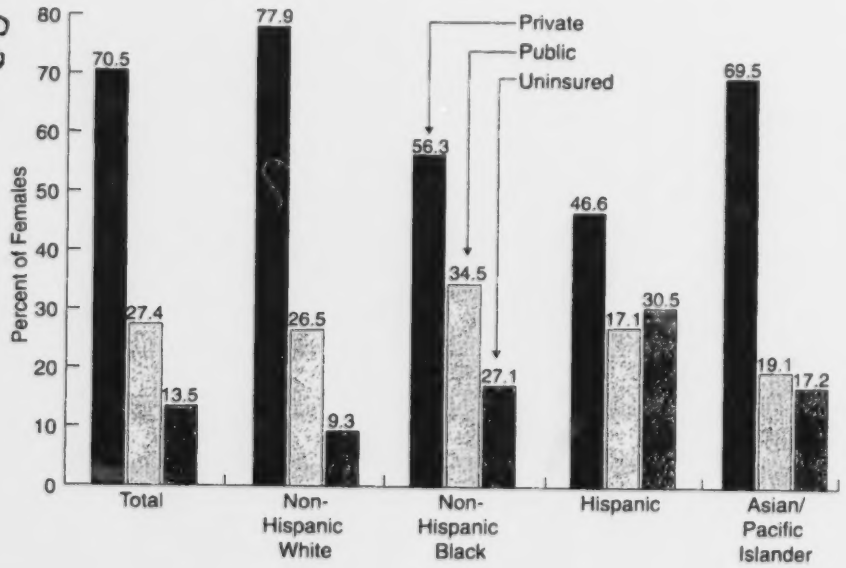
In 2001, non-Hispanic White females were the most likely to be covered by private insurance (77.9 percent) as compared to other racial and ethnic groups and the least likely to be uninsured (9.3 percent). Hispanic females were the most likely to be uninsured (30.5 percent) followed by Black and Asian/Pacific Islander women (17.2 and 17.1 percent, respectively).

In 2001, 19.5 million females and 21.7 males lacked health insurance. Among adults aged 18-54, women were less likely to be uninsured than men, with the greatest difference between men and women aged 21-24. This may be attributable to the greater proportion of women of childbearing age enrolled in Medicaid. Among persons aged 55-64, however, women were more likely than men to be uninsured. Most adults aged 65 and older are covered by Medicare, a public insurance program.

1Bloom B, Simpson G, Cohen RA, Parsons PE. Access to health care. Part

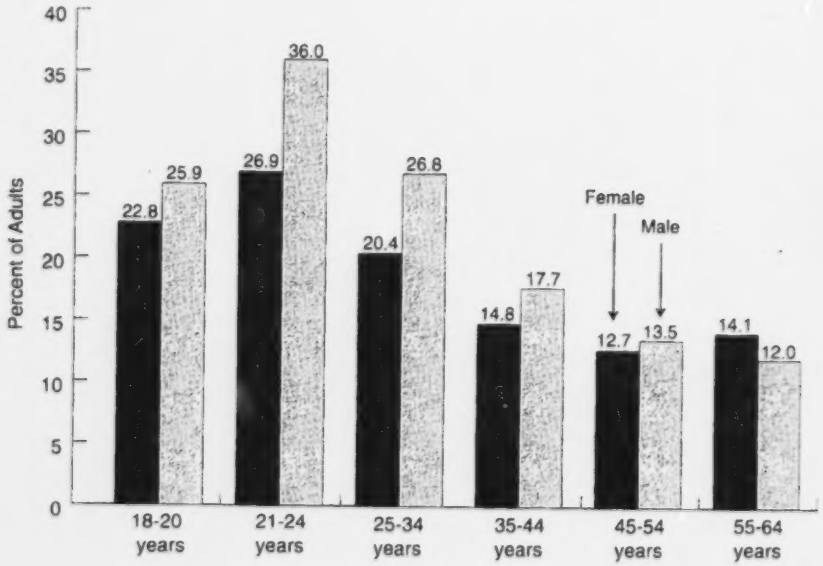
Health Insurance Coverage of Females, by Type of Coverage and Race/Ethnicity, 2001

Source (III.2): Current Population Survey



Adults Without Health Insurance, by Age and Sex, 2001

Source (III.3): Current Population Survey



MEDICARE AND MEDICAID

Medicare is a national health insurance program for people aged 65 and older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). The Medicare program consists of two parts. Part A covers hospital, skilled nursing facility, home health, and hospice care. Part B covers doctors' services, outpatient hospital services, and durable medical equipment. Among the covered preventive services are an annual mammogram, Pap smear, bone density scan, and influenza vaccination.

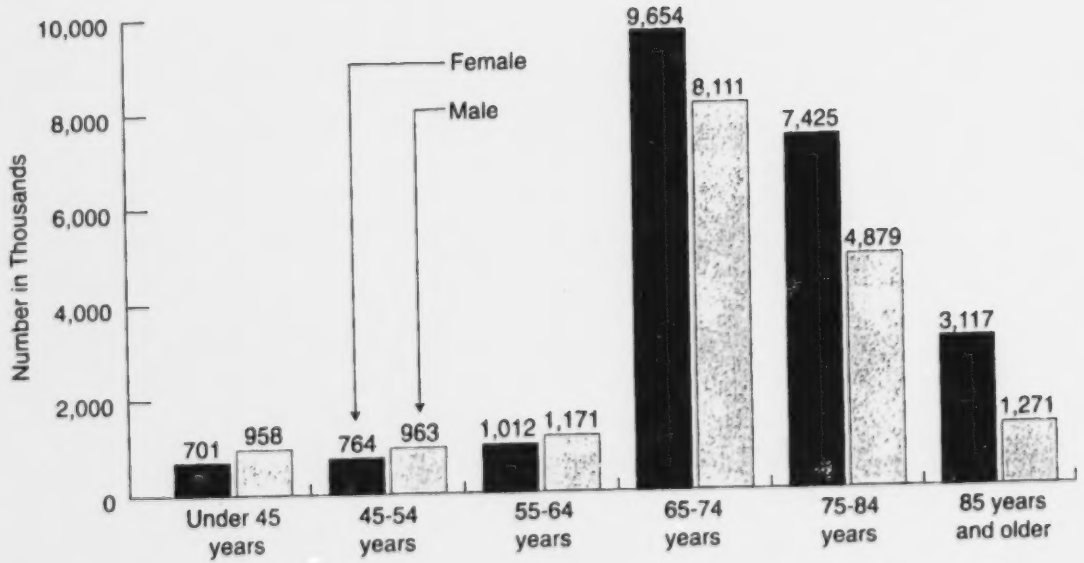
In 2001, Medicare had over 40 million enrollees, of whom 56.6 percent were female. The large majority of all Medicare enrollees were aged 65 and older, but this age group represented a larger segment among female than male enrollees (89.1 compared to 82.2 percent). Females represented 45.6 percent of the 356,319 enrolled in the Medicare End-Stage Renal Disease program.

Medicaid provides coverage for eligible individuals and families with low incomes/resources. Jointly funded between Federal and State governments, Medicaid covers approximately 40 million individuals including children, the aged, blind and/or disabled, and people who are eligible for cash assistance programs.

In 1999, slightly more than half of all Medicaid recipients were female. Fifty-one percent of all Medicaid recipients were under 21, 28.9 percent were between the ages of 21-64, and 10.7 were 65 and older (9.5 percent were unknown).

Medicare Enrollees (All Ages), by Age and Sex, 2001

Source (III.4): Centers for Medicare and Medicaid Services



PREVENTIVE CARE

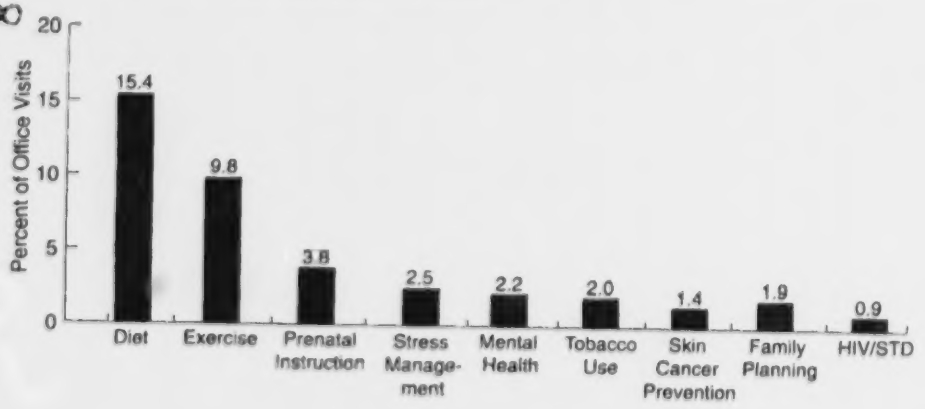
Prevention of health problems and promotion of optimal physical and emotional functioning are important components of clinical interactions. In 2000, females made 488 million office visits and males made 335 million. Of the visits made by women, 21.2 percent were made for preventive, prenatal, and other non-illness care. Other office visits made were for acute problems, chronic illness, or visits related to surgery or injury.

Preventive care often takes the form of counseling and educational services provided during office visits. In 2000, the most common type of counseling or educational services provided or ordered for females was that related to diet (15.4 percent) and exercise (9.8 percent). Prenatal instruction was the third most common service ordered, provided during 3.8 percent of office visits. Counseling and educational services related to stress management, mental health, and tobacco use were provided in less than 3 percent of office visits.

In 2003, the U.S. Preventive Services Task Force revised their recommendations for screening for cervical cancer. Pap smears should begin three years after sexual activity begins, or at the age of 21, whichever comes first. Screening should be performed at least every 3 years for women, until the age of 65. After age 65, women who have had normal Pap smears and are not otherwise at increased risk for cervical cancer need not be screened. The Task Force also recommends that all women aged 40 and older have a screening mammogram every 1 to 2 years to detect breast cancer. Although more women adhered to the recommendations for Pap smears than mammograms in 2001, the majority of women of all racial and ethnic groups received a Pap smear within the past 3 years and a mammogram within the past 2 years. Non-Hispanic Black women had the highest proportion reporting receipt of a Pap smear in the past 3 years (85.3 percent) and non-Hispanic White women had the highest proportion reporting receipt of a mammogram in the past 2 years (72.1 percent).

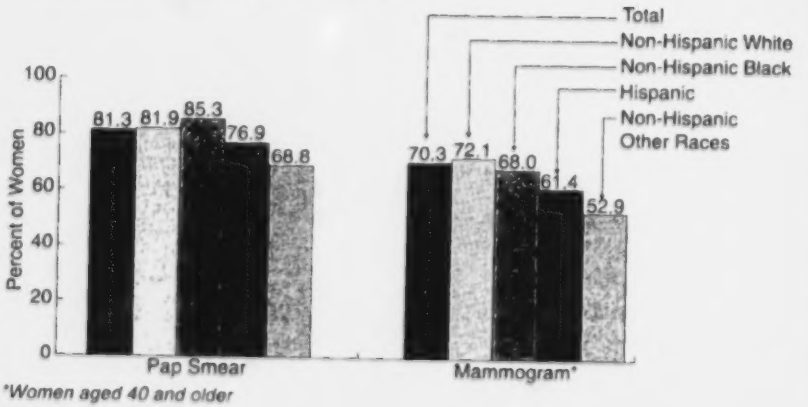
Counseling/Education Provided to Females (All Ages) During Office Visits, 2000

Source (III.5): National Ambulatory Medical Care Survey



Women's Self-Report of Pap Smears (In Past Three Years) and Mammograms (In Past Two Years), by Race/Ethnicity, 2000

Source (III.6): National Health Interview Survey



*Women aged 40 and older

TITLE X FAMILY PLANNING SERVICES

Title X is a national program authorized through the Public Health Service Act to reduce unintended pregnancy by providing contraceptive and related preventive health care services to low-income individuals. In 2001, 89 Title X grantees operated 4,590 clinics. These clinics served 4,857,717 family planning users, of whom 95.9 percent were females. Among females using Title X family planning services, 59.8 percent were under 25 years old, and only 2.4 percent were aged 45 years or older. Although male users had similar age patterns, they were slightly more likely than females to be teenagers (33.9 percent versus 28.9 percent).

In 2001, nearly two-thirds (64.0 percent) of female Title X family planning users were White; 21.2 percent were Black; 3.1 percent were Asian/Pacific Islander; and 0.7 were percent Native American. The remaining 11.0 percent of users' races was unknown. Of the female Title X recipients, 20.3 percent identified themselves as Hispanic or Latino and may be of any race.

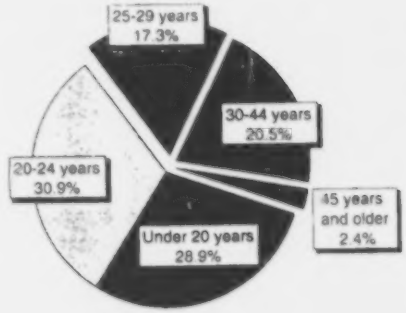
Nearly two-thirds (65.4 percent) of all Title X family planning users had incomes at or below the Federal poverty level in 2001. Another 17.1 percent had family incomes between 101 percent and 150 percent of the poverty level, and 6.8 percent had incomes that were 151 percent to 200 percent of poverty. Only 8.7 percent had incomes that were more than 200 percent of poverty.[1]

Over 4 million or 87.5 percent of the family planning users reported use of a contraceptive method. Among females not currently using a contraceptive method, almost half (42.2 percent) were not using a method because they were pregnant.

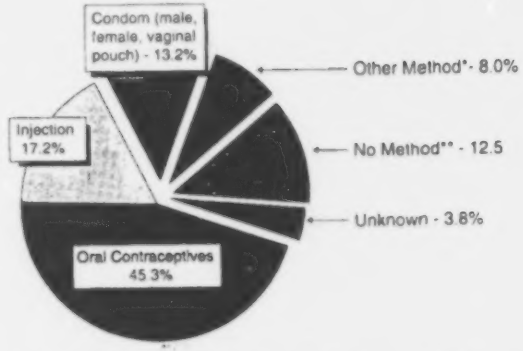
Title X funds were also used to provide 3,047,310 Pap smear tests and 2,853,669 clinical breast examinations. In addition, 5,111,547 tests for sexually transmitted diseases (STD) and 601,259 Human Immunodeficiency Virus (HIV) tests were provided to both female and male clients.

[1]The income status for 2.0 percent of Title X family planning users was unknown.

Women Using Title X Family Planning Services, by Age, 2001
Source (III.7): Office of Population Affairs



Contraceptive Methods for Women Using Title X Family Planning Services, 2001
Source (III.7): Office of Population Affairs



**Other method includes: sterilization (user or partner); IUD; diaphragm; cervical cap; spermicidal foam, jelly or cream, or contraceptive film (used without another method).*

***No methods include: pregnant, and no method used for other reasons.*

TITLE V ABSTINENCE EDUCATION PROGRAMS

In 1999, 49.9 percent of high school students reported having had sexual intercourse, and over one-third reported having had sexual intercourse in the previous 3 months. Early adolescent sexual intercourse may have negative effects on social and psychological development and has been linked with alcohol and drug use, violence, delinquency, and school-drop out.[1,2] Abstinence-only education programs create an environment within communities that supports teen decisions to postpone sexual activity until marriage.

Since 1998, States and Territories have utilized Abstinence Education funding under Title V, Section 510 of the Social Security Act to promote abstinence education. In 2001, 53 of 59 States and Territories received $43.5 million in funds through the Abstinence Education Grant Program administered by the Health Resources and Services Administration to provide abstinence education, mentoring, and counseling. In addition to abstinence education, most programs offer education on topics including self-esteem building, avoiding risky behavior, and aspiring to marriage.

With this funding, a majority of States have awarded contracts to local organizations to promote abstinence education. In 2000, States/Territories awarded contracts to 36 community-based, 29 youth-serving, and 21 faith-based organizations. Using local partners, States/Territories were able to target special populations including parents (46 grantees) and teachers and other professionals working with youth (29 programs).

Through this program, a total of 1,280,510 clients received direct services in 1999. Of these, nearly 84 percent were between the ages of 10 and 17 years. Program participants included 595,683 males and 684,827 females (47 and 53 percent, respectively). Over 60 percent of the program participants were White compared to 21 percent Black and 11 percent Hispanic, with the remainder of participants of other or unknown race/ethnicity.

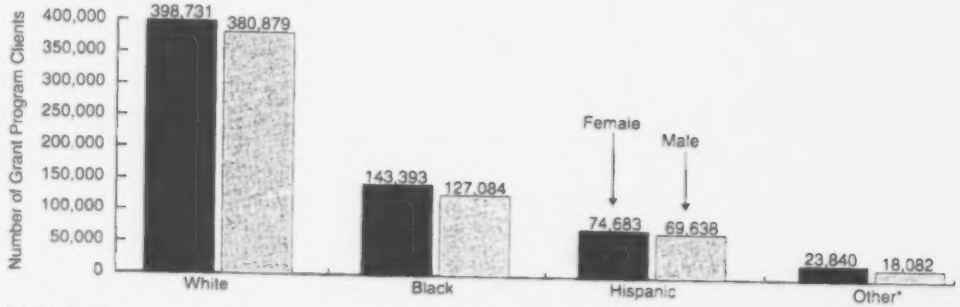
Additional Title V funding for abstinence education is provided through Special Projects of Regional and National Significance, which provide support to public and private entities for development and implementation of community-based abstinence education programs. Between 2001 and 2003 funding has increased from $20 million to $55 million.

1Centers for Disease Control and Prevention. CDC Surveillance Summaries, MMWR 2000;49(SS-5).

2Ventura SJ, Mann JA, Matthews TJ, Hamilton BE. Births to Teenagers in the United States, 1940-2000. National Vital Statistics Reports Sept 2001;49(10). http://www.cdc.gov/nchs/data/nvsr/nvsr49/nvsr49_10.pdf

Abstinence Education Grant Program Clients Served, by Sex and Race/Ethnicity, 1999

Source (III.8): Health Resources and Services Administration



"Under the category of "Other" 689 males and 1,932 females were reported as Native Americans.

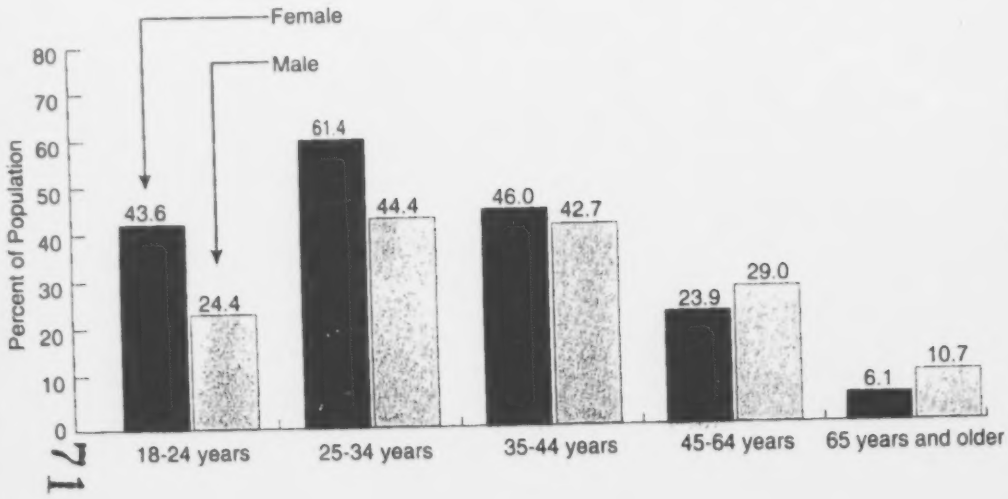
Note: Data were incomplete for an additional 44,160 clients served by the grant programs.

HIV TESTING

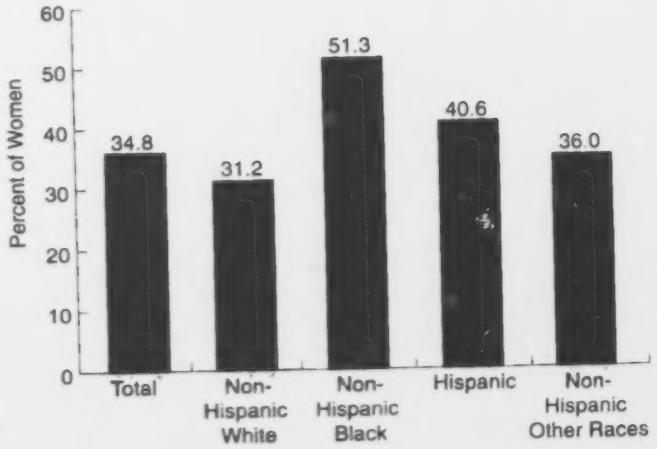
Testing for human immunodeficiency virus (HIV), the virus that causes AIDS, offers an opportunity to alert infected persons to the need for treatment. Women aged 25-34 years reported the highest rates of ever being tested for HIV (61.4 percent). The percent of women who reported being tested declined with increasing age, with only 6.1 percent of women aged 65 and older reporting ever being tested. For adults aged 18-44, women were more likely than men ever to have been tested for HIV, but this trend was reversed for adults aged 45 and older, with men more likely than women ever to have been tested.

Among U.S. adult women, non-Hispanic Black women were the most likely to have ever been tested for HIV (51.3 percent) and were 1.6 times more likely to have been tested than non-Hispanic White women (31.2 percent).

Adults Aged 18 and Older Who Have Ever Been Tested for HIV, by Age and Sex, 2001
Source (III.1): National Health Interview Survey



Women Aged 18 and Older Who Have Ever Been Tested for HIV, by Race/Ethnicity, 2001
Source (III.1): National Health Interview Survey



MEDICATION USE

In 2000, medication use was reported during 66.1 percent of the 823.5 million visits to physician offices in the U.S. Medication use includes all new or continued prescription and non-prescription medications ordered, supplied, or administered. Types of medication use most frequently reported for females reflected their most common diagnoses (excluding pregnancy) of hypertension, acute upper respiratory infections, and diabetes mellitus.

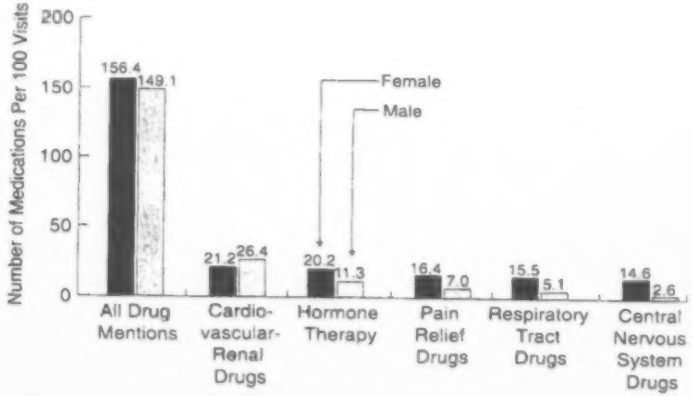
Overall, higher rates of medication use were reported for females (156.4 drugs per 100 visits) than males (149.1 drugs per 100 visits). Cardiovascular-renal drugs were the most frequently reported medications used by both sexes, however, males had slightly higher rates of use (26.4 compared to 21.2 drugs per 100 visits).

Medication use varied among females by type of medication and age. Rates of use for cardiovascular-renal drugs increased considerably with age, with women aged 75 and older having the highest rate (60.1 drugs per 100 visits). Pain relief medication use also increased with age, with women aged 65 and older having the highest rates of use. Hormone therapy was the most frequently reported medication used by women aged 45-64 and the second most frequently reported medication used by women aged 65 and older, after cardiovascular-renal drugs. Use of central nervous system drugs, including sedatives, antidepressants, and anti-anxiety agents, peaked among women aged 45-64, while respiratory tract drugs had the highest rate of use among females aged 15 years and younger.

The five most frequently reported medications used by females according to therapeutic classification were Premarin (hormone replacement therapy), Synthroid (for the treatment of thyroid disease), Claritin (for allergy relief), Celebrex (for arthritis pain relief), and Lipitor (for lowering cholesterol). The top five generic substances taken by women were acetaminophen, amoxicillin, albuterol, aspirin, and calcium.

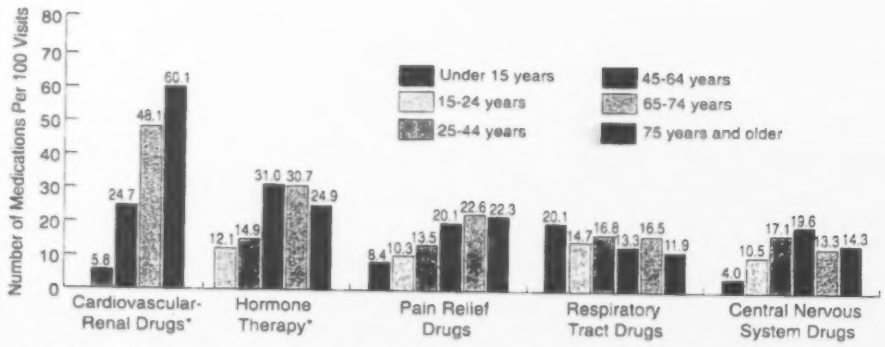
Medication Use Reported During Physician Office Visits, by Sex (All Ages), 2000

Source (III.9): National Ambulatory Medical Care Survey



Medication Use Reported For Females During Physician Office Visits, by Age, 2000

Source (III.9): National Ambulatory Medical Care Survey



*Insufficient number of cases reported for certain age groups.

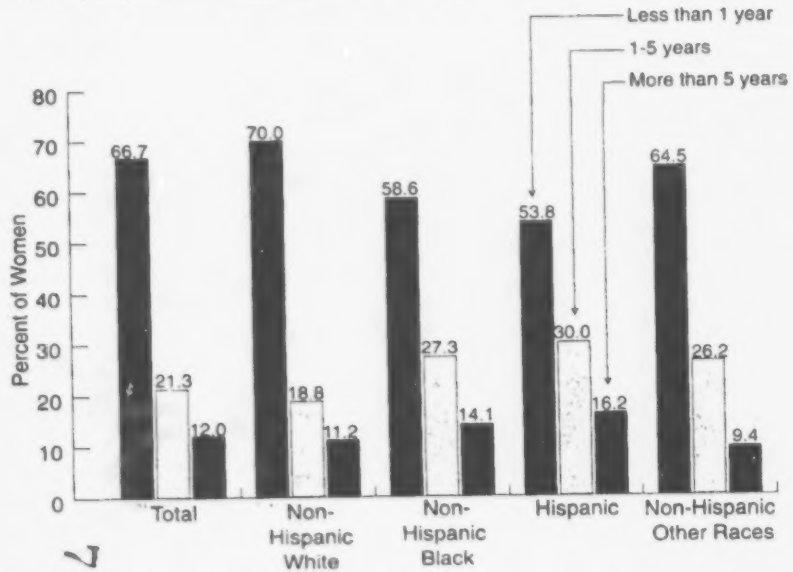
DENTAL CARE

While the majority (66.7 percent) of women reported having visited a dentist in the last year, 12.0 percent reported they had not visited a dentist in more than 5 years. Hispanic women were the most likely (16.2 percent), as compared to women of other racial and ethnic groups, to report that they had not received dental care for 5 years or more.

Income was strongly associated with reported receipt of dental care, with women's likelihood of having seen a dentist in the past year increasing with family income. Women in families with incomes greater than or equal to three times the Federal poverty level were much more likely than women with lower family incomes to have seen or spoken with a dentist in the past year. Women with family incomes below the poverty level were the least likely to have had dental care in the past year (47.5 percent) and the most likely to have gone 5 years or more without any dental care (22.6 percent).

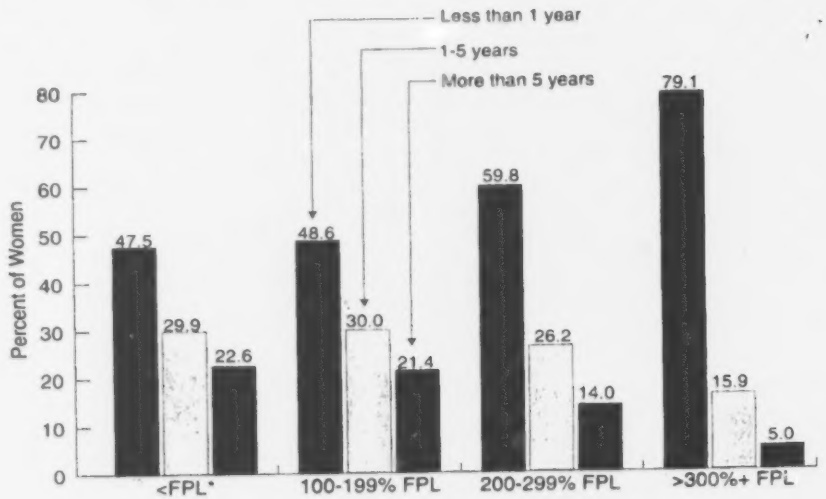
Report by Women Aged 18 and Older of Time Since Last Seen or Talked to a Dentist, by Race/Ethnicity, 2001

Source (III.1): National Health Interview Survey



Report by Women Aged 18 and Older of Time Since Last Seen or Talked to a Dentist, by Poverty Status, 2001

Source (III.1): National Health Interview Survey



*FPL is the Federal Poverty Level

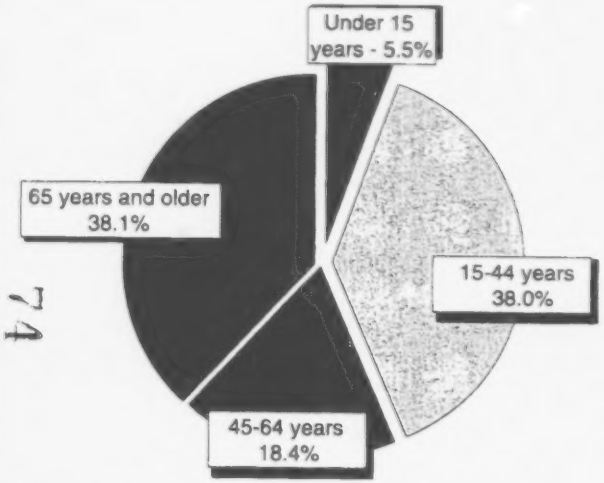
HOSPITALIZATIONS

Females represented 60.5 percent of all hospital discharges in 2000. Most of these hospitalizations occurred among women aged 15-44 and 65 years and older. The high percentage of hospitalizations for women aged 15-44 years corresponds with the high rate of childbirth during these ages; delivery is the most common hospital discharge diagnosis, representing 263.0 hospitalizations per 10,000 women in 2000.

Overall, females had a much higher hospitalization rate than males (1350.5 vs. 920.2 per 10,000 population). Both females and males were hospitalized at high rates for diseases of the circulatory and respiratory systems. However, females had higher hospitalization rates than males for diseases of the digestive, genitourinary, and musculoskeletal systems; for cancer; and for the broad category of endocrine, nutritional, and metabolic diseases and immunity disorders. Males had slightly higher rates of hospitalization for mental disorders as well as injuries and poisonings.

Discharges from Non-Federal Short-Stay Hospitals for Females (All Ages), by Age, 2000

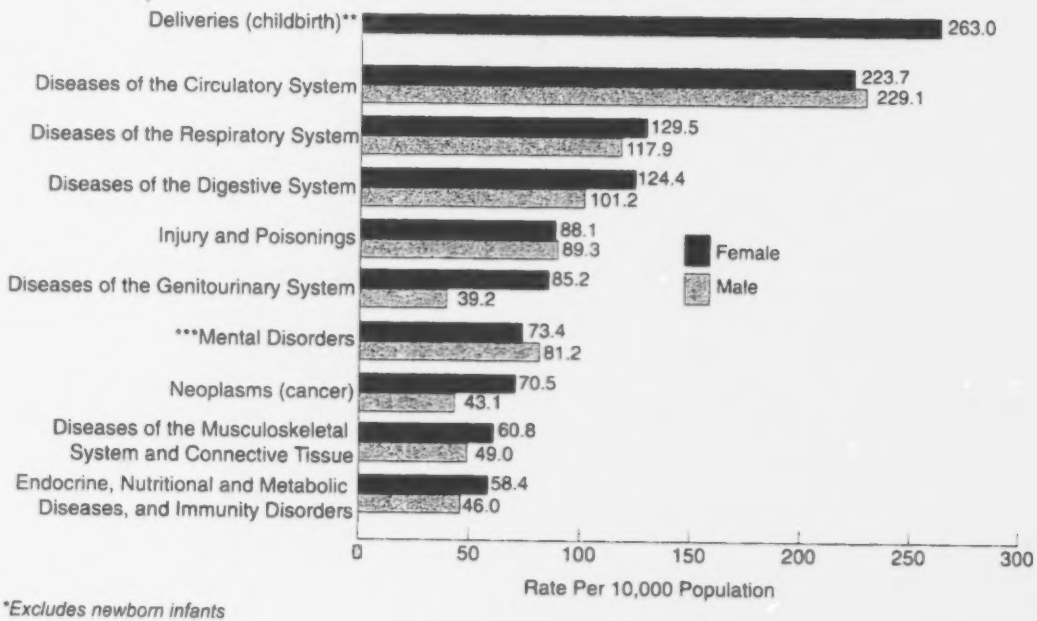
Source (III.10): National Hospital Discharge Survey



Notes: Discharges of inpatients from non-Federal hospitals. Excludes newborn infants.

Discharges from Non-Federal, Short-Stay Hospitals, by Sex and Primary Diagnosis (All Ages),* 2000

Source (III.10): National Hospital Discharge Survey


Deliveries (childbirth)** 263.0
Diseases of the Circulatory System 223.7 229.1
Diseases of the Respiratory System 129.5 117.9
Diseases of the Digestive System 124.4 101.2
Injury and Poisonings 88.1 89.3
Diseases of the Genitourinary System 85.2 39.2
***Mental Disorders 73.4 81.2
Neoplasms (cancer) 70.5 43.1
Diseases of the Musculoskeletal System and Connective Tissue 60.8 49.0
Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders 58.4 46.0
Female
Male
0 50 100 150 200 250 300
Rate Per 10,000 Population

**Excludes newborn infants*

***Not applicable to males*

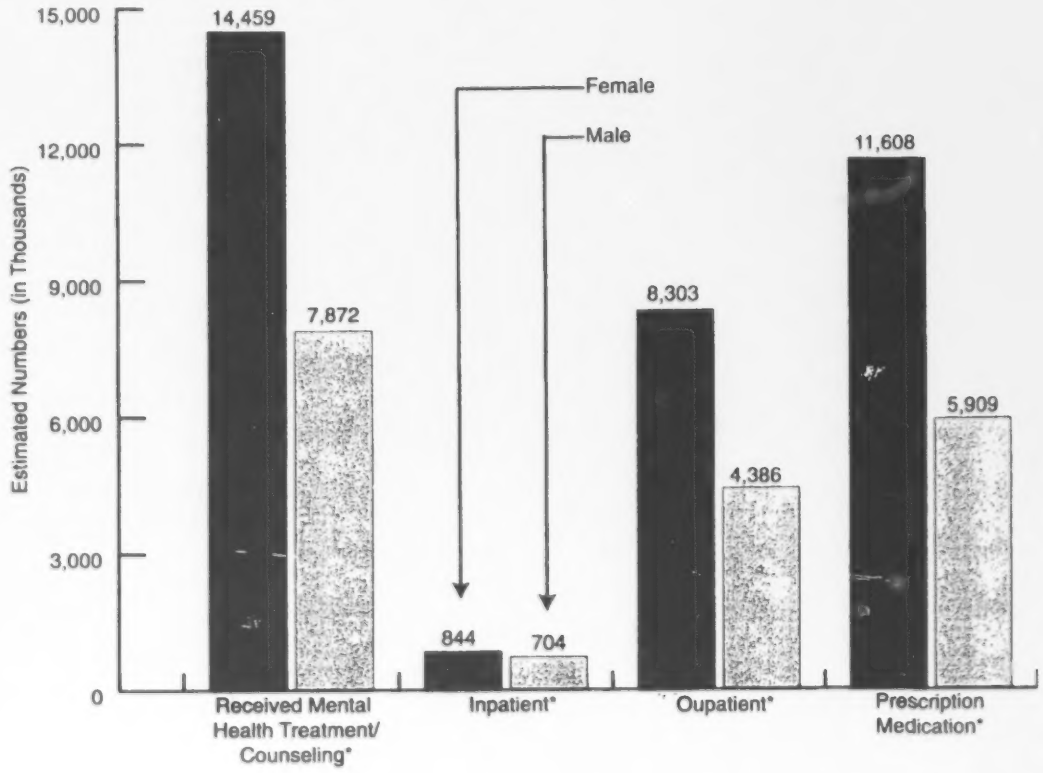
MENTAL HEALTH CARE UTILIZATION

Mental health care is needed, but not received, by millions of adults in the U.S. In 2001, 5.7 million women and 2.7 million men reported an unmet need for treatment or counseling for mental health problems.

The estimated number of women receiving mental health treatment or counseling (including inpatient care, outpatient care, and prescription medication) increased from 13.2 million in 2000 to 14.5 million in 2001. The most common type of treatment for mental health conditions for both women and men was prescription medication, followed by outpatient treatment. Although a greater number of women than men received inpatient treatment, a smaller proportion of women with a mental health condition received inpatient care than did men with a mental health condition (5.8 compared to 8.9 percent). It should be noted that inpatient data presented here do not include inpatient care for drug or alcohol treatment; when drug and alcohol diagnoses are included, the number of men receiving inpatient care exceeds the number of women receiving care in inpatient settings.

Adults Aged 18 and Older Receiving Mental Health Care Treatment, by Sex and Treatment/Counseling Type,* 2001

Source (III.11): National Household Survey on Drug Abuse



*Respondents were to exclude treatment for alcohol or drug use.

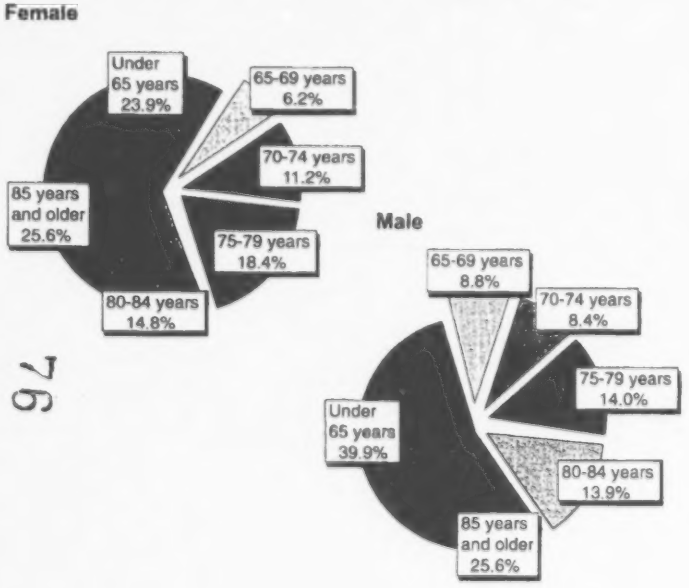
HOME HEALTH AND HOSPICE CARE

An increasing number of individuals are receiving health care at home or community-based settings rather than in institutions. In 2000, 1,355,300 Americans received home health care services. Of these, females comprised 877,900 (64.8 percent) of recipients. The majority of women receiving home health care were aged 65 years or older (76.1 percent). Women aged 85 and older received 25.6 percent of home health care, followed by women between the ages of 75-79 (18.4 percent).

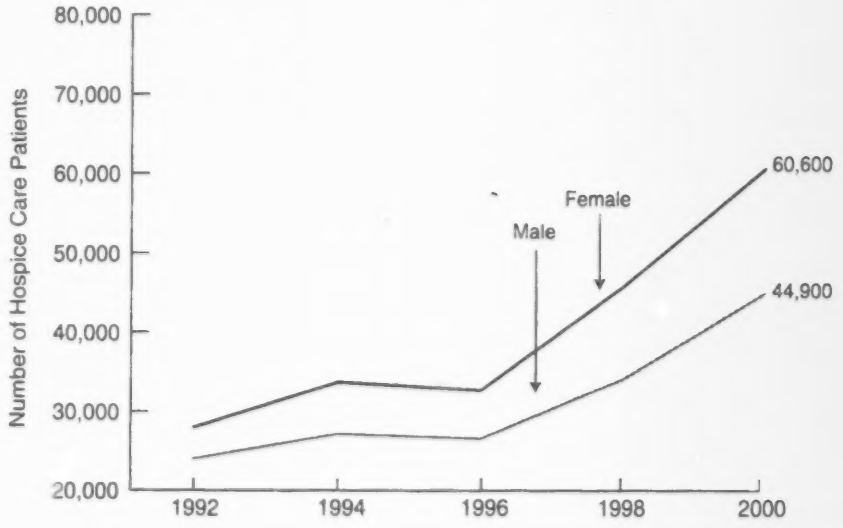
In 2000, 73.2 percent of female and 78.3 percent of male home health care patients received skilled nursing services. Additional services commonly provided to home health patients include personal care, physical therapy, and homemaker household services (provided to 36.9 percent, 26.7 percent, and 26.5 percent of female home health patients, respectively).

Increasing numbers of women and men are turning to hospice care to meet their end-of-life needs. Between 1992 and 2000, the number of hospice care patients increased from 52,000 to 105,500. Women narrowly outnumbered men in the number of hospice care patients, comprising 53.5 percent of patients in 1992 and 57.4 percent of patients in 2000.

Current Health Care Patients, by Age and Sex, 2000
Source (III.12): National Home Health and Hospice Care Survey



Hospice Care Patients (All Ages), by Sex, Selected Years 1992-2000
Source (III.12): National Home Health and Hospice Care Survey



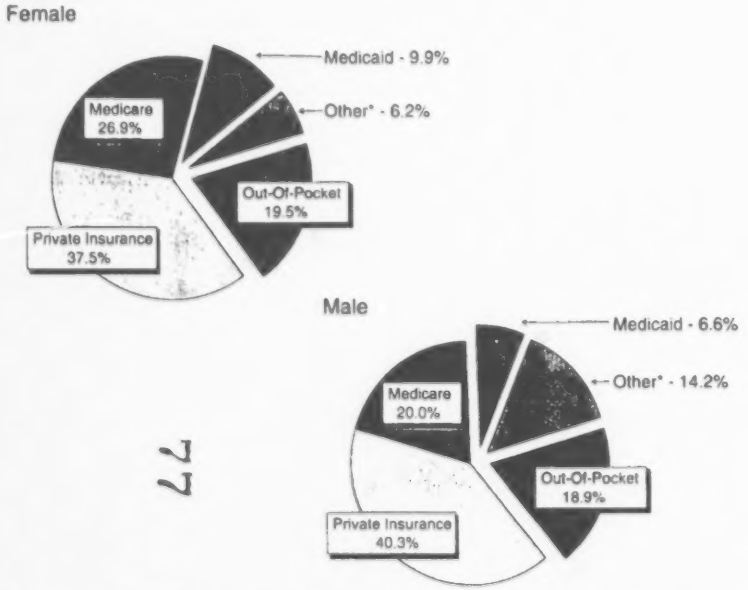
HEALTH CARE EXPENDITURES

While the majority of health care expenses were paid for by some type of private or public insurance in 1998, 19.5 percent of health care expenses for females were paid out-of-pocket. Females were more likely than men to pay for their health care expenses out-of-pocket, through Medicare, or through Medicaid, and less likely to pay for their expenses through private insurance or other sources.

Among those who had health care expenditures in 1998, the average expense for health services for females was higher than for males ($2,712 compared to $2,132). In addition to total health service expenses, females averaged higher expenditures for prescription medications, dental services, office-based services, and home health services. The most expensive services for females were hospital inpatient services and home health services, which averaged $10,353 and $4,107, respectively.

Health Care Expenses, by Source of Payment and Sex (All Ages), 1998

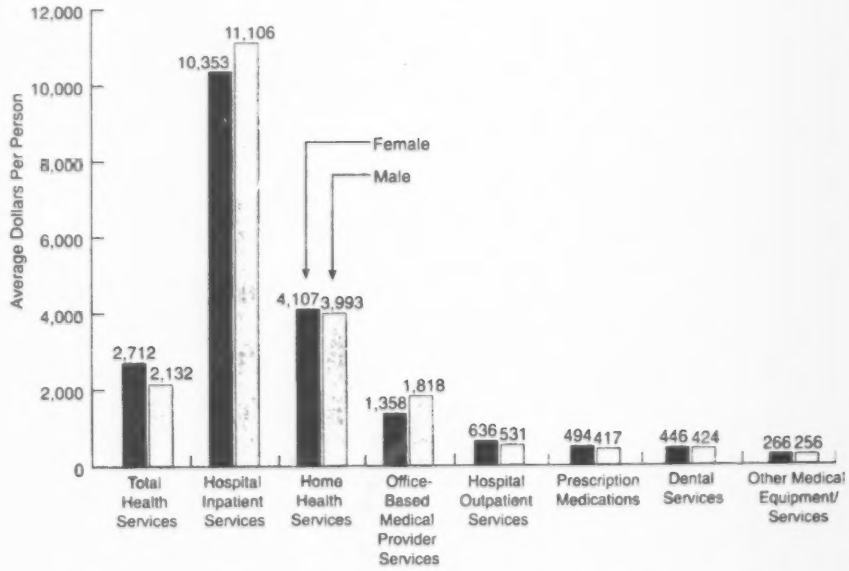
Source (III.13): Medical Expenditure Panel Survey



*Includes public programs such as Department of Veterans Affairs (except CHAMPVA), other Federal sources

Annual Mean Health Care Expenses for Persons (All Ages) with an Expense, by Sex and Category of Service, 1998

Source (III.13): Medical Expenditure Panel Survey



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CONTRIBUTORS

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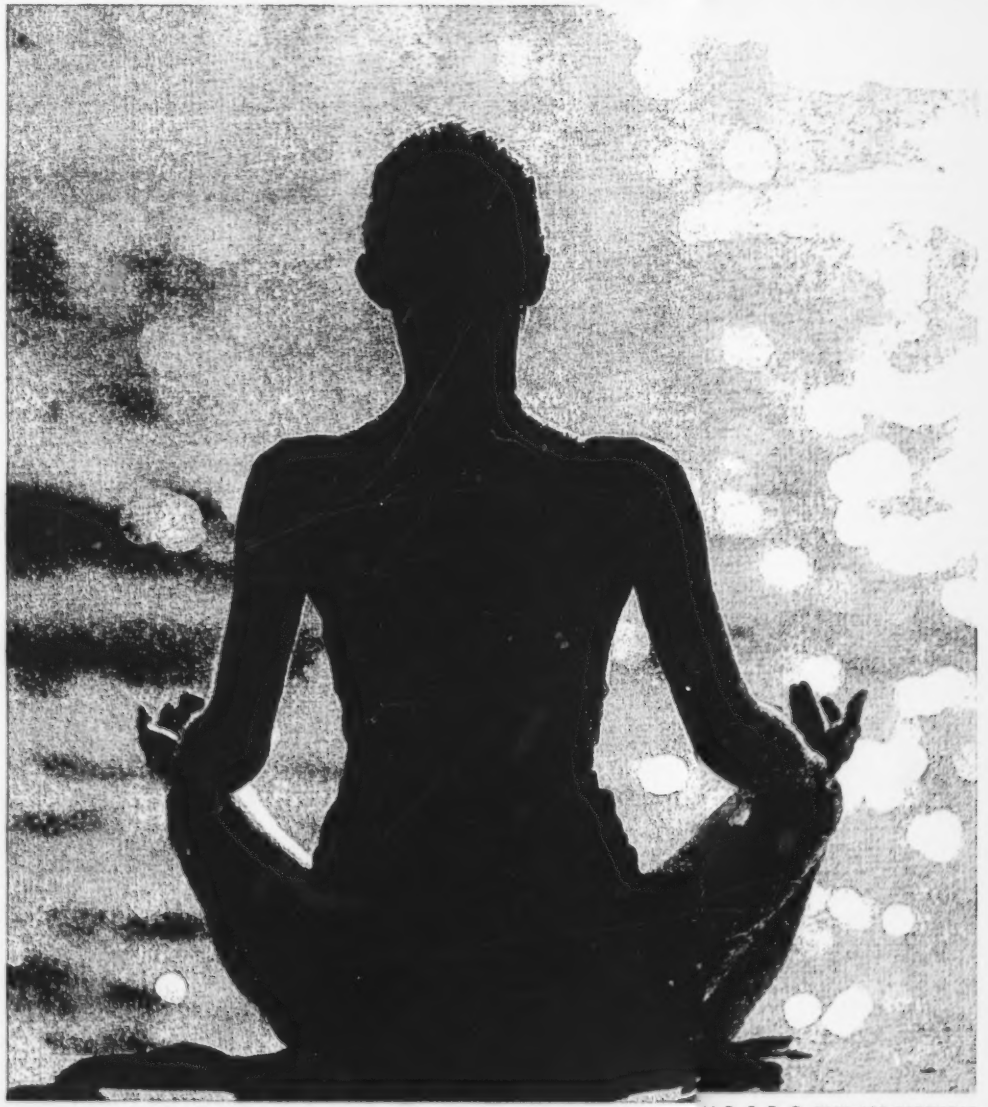

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